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ACQUIRED IMMUNE DEFICIENCY SYNDROME PREVENTION

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

SPECIAL HEARING

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ACQUIRED IMMUNE DEFICIENCY SYNDROME PREVENTION

MONDAY, FEBRUARY 14, 2000

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
San Francisco, CA.

The subcommittee met at 12 noon, in the Hiram Johnson State Office Building Auditorium, 455 Golden Gate Avenue, San Francisco, CA, Hon. Arlen Specter (chairman) presiding.

Present: Senator Specter.

Also present: Senator Boxer and Representative Pelosi.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Good afternoon, ladies and gentlemen, and welcome to the hearing of the Appropriations Subcommittee on Labor, Health, Human Services and Education.

Last July, the subcommittee convened a hearing here, and I had occasion to be in the vicinity on other activities and thought it would be useful to have a hearing on AIDS prevention. And I am delighted to be joined by two of my colleagues from Washington. From the Senate, Senator Boxer, and from the House of Representatives, Congresswoman Nancy Pelosi.

And the subject that we are taking up today is one of great national importance and special importance in this area. We are beginning to focus now on the funding for fiscal year 2001, and this hearing will provide some insights as to what we ought to be doing in that respect.

Senator Harkin was here for our July hearing and wanted to be here today in his capacity as ranking Democrat, but could not be here. But Senator Harkin and I, with co-sponsors, filed a resolution last week to increase the National Institutes of Health funding to $2.7 billion.

In the course of the past 3 years that funding has been increased by more than $5 billion, over $900 million 3 years ago, $2 billion 2 years ago, $2.3 billion last year. And it is my view that the NIH is the Crown Jewel of the Federal Government. It may, in fact, be the only jewel of the Federal Government.

And there have been enormous results. And there are quite a number of battles to fight along that line, one I might mention very briefly. What where we are looking for national support is on the battle to take away the restriction limiting NIH from funding research on embryos.

NIH, according to a legal opinion, can research on stem cells once removed from embryos but not from embryos. And that is going to be a big issue coming up, where not giving you any of the history, Senator Lott has promised to put that on as a freestanding bill.

I am pleased to note from our subcommittee there were very substantial increases in a lot of the critical funding areas. NIH on AIDS went from under $1.8 billion to over $2 billion.

CDC/HIV AIDS prevention went from $657 million to $730 million. ACDP went from $461 million to $528 million. Ryan White funding went from a little over $1.4 billion to almost $1.6 billion.

And we are going to try to maintain these funding levels in the future with proportionate increases, as we have in the past. And, candidly, that is a tough battle for a lot of reason which I will not belabor here this afternoon.

We have a very distinguished array of witnesses.

It is hard to make a selection of who will go next, but I guess Senate protocol——

Senator BOXER. Yes.

Senator SPECTER [continuing]. Turns to you, Senator Boxer.

OPENING STATEMENT OF SENATOR BARBARA BOXER

Senator BOXER. Well, thank you very much. And I don't think that Congresswoman Pelosi and I mind who goes first, because we are a team.

I just want to say to you, Senator Specter, it is very important that you continue this incredibly focused effort on this disease. We are so pleased you are back here again.

And Congresswoman Pelosi, my friend, she is really the leader in the House on this and, in many ways, a national leader in getting more AIDS funding.

So it is an honor to be here with you.

My schedule is such that I have about an hour. So I am going to be brief in my opening statement.

I will make some brief points and go quickly through them.

First of all, the last time you were here, I want to thank you for that because you had Congressman Ron Dellums, if you remember, come speak to us. And he pointed out the AIDS in Africa issue like no one else had done before. And as a result of his amazing leadership, Congressman Barbara Lee wrote a bill, sort of a Marshall Plan, against AIDS in Africa. And I picked up on her effort in the Senate and have introduced a bill through my——

Mr. PETRELIS. I am a person with AIDS. My name is Michael Petrelis. And I am here to talk about the money——

Senator SPECTER. No, that's all right. Now wait——

Mr. PETRELIS [continuing]. That is sent here where we cannot buy——

Senator SPECTER. Wait a minute, officer. Officer, leave him alone.

Mr. PETRELIS. Stop sending money without accountability. As a person with AIDS I am really angry.

There was no announcement about this meeting here in San Francisco.

You honorable people have come here. You do not have people with AIDS who are unconnected to the money you are sending

here. Now we have had major problems in San Francisco where we cannot follow the money, where we cannot have access to services. This is in despite of the fact that for HIV Prevention Services in San Francisco we get $8 million, $8 million. You can't find a condom in the gay bars. When are you going to listen to us? We have high salaries at the AIDS industry. And people here in San Francisco are going without having subsidies. I would like some answers, please.

Senator SPECTER. Thank you, thank you very much. We are going to proceed as our hearing. And we'd be glad to postpone——

Mr. PETRELIS. AIDS is decreasing in San Francisco and nationwide. Why do you keep promoting terror? Why do you keep funding AIDS terror when the statistics are down. AIDS is disappearing. People are not taking the deadly drugs and they are living longer.

Why don't you tell the truth about needs, Nancy Pelosi, Arlen Specter, Senator Boxer? AIDS is over.

Ms. PELOSI. Thank you very much for your contribution.

Senator BOXER. Thank you very much.

Senator SPECTER. OK. Thank you very much.

Mr. PETRELIS. I want to say there needs to be a place at the table for those of us who do not take the treatment that are healthy and living long, healthy and vitalized, being ignored by these panel leaders, because we are not for funding.

Senator SPECTER. Officer. Officer, don't—leave him be. Leave him be.

Mr. PETRELIS. We are not for funding. I have had AIDS for 5 years. My hair is not falling out. I refused all medical treatments. And I refuse to believe that. I am a very strong person. It's the percentage of the indigent people around here who judge cold facts with the same precision that people with AIDS are dying today.

And what we ask for you, respectfully, is to reevaluate this drug into body, this hype early, because what you are doing is giving healthy people 50 pills a day. And it will kill them.

And what we need from you, please, is a place at the table for those of us that are unconnected that defy the norm here in the city that thrive with this disease. We deserve a place in your office just as much as those who are paid for by the pharmaceutical companies. And we need your help.

Senator SPECTER. We would be willing to hear from you. We would like to proceed in an orderly way.

Mr. PETRELIS. When is public comment for people with AIDS unconnected to the AIDS industry?

Ms. PELOSI. Michael, the Senator was very courteous in hearing you out. Thank you for your contribution to it.

Senator SPECTER. We would be——

Mr. PETRELIS. I am hearing two different things from you.

Senator SPECTER. Well, I am presiding at this hearing. And it is my——

Mr. PETRELIS. You looked terrible on "20/20", by the way. You looked terrible on "20/20".

Ms. PELOSI. Michael. Michael——

Mr. PETRELIS. We want that ability, Nancy, with every breath we have, because the wind is blowing, Nancy. The wind is blowing.

Ms. PELOSI. The Senator has been very gracious to hear you out. Thank you for your contribution.

Mr. PETRELIS. After 2 years demanding accountability, yes, you are finally hearing us. You can point your finger, Nancy.

Ms. PELOSI. Michael, thank you.

Mr. PETRELIS. AIDS has the ability and——

Ms. PELOSI. Your contribution is over.

Mr. PETRELIS [continuing]. Here it is, staying. And I would like to know why the HPPC did not make the announcement—UCSF. It's all AIDS industry, pharmaceutical industry subsides. And people are dying without—it needs to stop.

Senator SPECTER. We have heard you.

Mr. PETRELIS. We need your help.

Senator SPECTER. Now would you mind—now would you mind——

VOICE. Why didn't you invite the public to this?

Senator SPECTER [continuing]. Sitting down——

VOICE. Why didn't you invite the public?

Senator SPECTER. The public has been invited.

Mr. PETRELIS. No, there was no——

VOICE. [continuing]. This place is empty, there is no public, Senator Specter. Why are you holding these in secret? Why are you holding these hearings in secret?

Senator SPECTER. If you gentlemen will sit down, we will be glad to hear from you when we complete——

VOICE. AIDS is a scam.

Senator SPECTER. I am aware of that. Would you please take a seat in the audience?

Mr. PETRELIS. Will you promise to help us?

Senator SPECTER. And when we have heard the listed witnesses we will be glad to hear from you, but we don't have to.

Will you please——

VOICE. Why did you fail to make the announcement about this meeting?

Senator SPECTER. If you do not sit down, you are going to be evicted right now.

Mr. PETRELIS [continuing]. Like people with AIDS, in San Francisco, who can't get a housing subsidy.

Senator SPECTER. All right, officer, escort them out.

Mr. PETRELIS. And we are very angry with this industry. Nancy Pelosi continues to subsidize her friends while people who are HIV-positive have no services.

VOICE. You can point your finger.

Mr. PETRELIS. Stop it, because you are endangering the safety of the public.

VOICE. As a Jewish woman, you know that from the government can make lists of anybody. You should be ashamed of yourself.

Senator SPECTER. Officer, escort——

VOICE. And you have done nothing——

Senator SPECTER. Officer, escort them out.

VOICE [continuing]. But allowed the greedy to get greedier. The complacency is with the greedy——

Senator SPECTER. Escort them out, officers.

VOICE. Are you aware that the executive director gets $180,000 a year. Do know how many people with AIDS you can feed with $180,000 a year?

Senator SPECTER. Officer, escort them out.

VOICE. We are not saying people are sick, but we are saying we need your help. And we just don't need you to spend money on the pharmaceutical companies. We don't need to subsidize the pharmaceutical companies. It is more of the treatment. We need housing, we need food, we need job training. We don't need more treatment. We need your help.

People with AIDS like me without the treatment are living long healthy lives. Don't ignore us. Stop fighting the AIDS spirit. The CDC is wrong. AIDS is not contagious. This epidemic is waning and it is because people are not taking poisoned AIDS drugs——

Senator SPECTER. We will now continue with Senator Boxer's opening statement.

Senator BOXER. As I was saying,——

VOICE. This isn't over. Let's talk about what AIDS is, OK?

Senator SPECTER. Will you escort the lady out, please?

VOICE. This is not a simple contagious disease. It's a group of illnesses. None of them are caused by a virus. OK? Let's talk about that.

Senator SPECTER. Officer, escort her out.

VOICE. You can throw us out of here, and you can have your little secret meetings, OK? But we've got your number. And the numbers are going down, and this is——

Senator SPECTER. Senator Boxer.

Senator BOXER. Mr. Chairman, I am pleased you are back. The last time you were here Ron Dellums was eloquent on the global nature of this disease. And as a result we have two strong bills pending in the Congress that would deal with it.

I am proud to say that Gordon Smith is my co-author, and it is called, "Global AIDS Funding," and I am looking forward to working with you on that.

As we have heard, this continues to be a very rough issue here in this area and all throughout the State. And we know we have to do more. What I am going to do, because we have wasted time in my opinion, because I think the opinions that were expressed could well have been expressed in a very simple straightforward way.

There is an opinion out there which needs to be heard and obviously has been heard by those physicians who care very deeply about this and political leaders who do, as well. We are doing our best with what science is telling us, and we will continue to follow science. This isn't about politics, or who shouts the loudest. It is about saving lives.

The fact that you are here, Mr. Chairman, means a great deal to Congressman Pelosi and myself. Again I will put all of the statements——

VOICE. Cut the cards right, Barbara.

Senator BOXER [continuing]. I will put all these——

VOICE. All she's——

Senator SPECTER. Will you please escort that man out, please?

VOICE [continuing]. You will be killing blacks and junkies and blacks and Latinos in this country——

Senator BOXER [continuing]. In the record. And I will continue to do the best that I can to work with you, Mr. Chairman.

Thank you.

Senator SPECTER. Officer, escort him out.

VOICE. You got bought-off groups like the HPPC and the DPH AIDS Foundation behind you, and we are sick of it. And it is not about science; it is about flocking, it is about greed—it is not over. The truth is coming out HIV is not called AIDS——

Senator SPECTER. Officer, escort him out.

VOICE [continuing]. The word is out and you can try the hype as long as you want. Sip your water, Barbara. Look pretty, Nancy. Smile, Arlen. But the truth is out. The AIDS fight is over. We want services, not salaries——

Senator BOXER. I am done.

Senator SPECTER. Congresswoman Pelosi.

STATEMENT OF HON. NANCY PELOSI

Ms. PELOSI. Thank you very much, Senator Specter. And thank you for coming to San Francisco again to talk about AIDS prevention which is very important.

We are about to hear from a very distinguished experienced panel about the impact of AIDS in our community. The fact is, is that the success that we have experienced here has been because we have listened to people. Our success is based on a community-based solution. It's about people coming together and forming a community-based solution which has served as a model to the rest of the country. That's why it is ironic that these people are saying they aren't listened to. Everyone is listened to in San Francisco.

So thank you for your courtesy, but as you know advocates by their nature are relentless, persistent and dissatisfied. We want to hear from our witnesses who were invited. We are glad you are here. We want to extend courtesy to you of the information we have to provide.

I just want to make a couple of points because I think it is important for you to know. In our eligible metropolitan area the AIDS epidemic has taken a tremendous toll. We have the highest rate of total AIDS cases per 100,000 residents. There are an estimated 20,000 people living with HIV infection in our eligible metropolitan area, 15,240 of whom live here in San Francisco. Over 8,200 San Franciscans are living with AIDS, an increase of 50 percent since 1991. And over 50 percent of people living with HIV are diagnosed with AIDS, a much higher proportion of EMA's.

The Health Department's AIDS Office reports that the demographics of the epidemic are changing here. Recent AIDS cases are more frequently people of color, 38 percent versus 25 percent cumulative. Women, 8 percent compared to 4 percent. Injection drug users and also drug users who are also men who have sex with men. A disproportionate number are African Americans. African Americans comprise 11 percent of San Francisco's population, yet make up 20 percent of our AIDS cases diagnosed since 1998. And during this same period a proportion of cumulative cases among

whites decreased from 75 to 62. That is where the decrease is. But the increase is in the African American community.

I have many more statistics that paint a very sad picture of the awful bite we take of this wormy apple called AIDS. And I'll submit them into the record in the interest of time.

I do want to thank you, Senator Specter, not only for having this hearing, but for your leadership on this issue, for helping us in very significant ways to increase the funding in all three areas: prevention, care, and research.

Frankly, you have made an enormous difference. And I know one of the reasons is because of Dorothy Mann, who testified here today, and her advocacy and education program in Pennsylvania. But for that reason I want to, on behalf of my constituents, thank you for what you had done and for coming back here for this hearing on prevention, prevention, prevention. Because whatever the debate is about how AIDS is spread or what the appropriate treatment is, one thing we all agree on is prevention is the order of the day. So we don't have to have people suffering from this.

Thank you very much, Senator.

Senator SPECTER. Thank you very much, Congresswoman Pelosi.

For the record, just a comment or two.

I am not unused to having outbursts at hearings. And my preference has always been to give a fair amount of latitude to see if we couldn't proceed without a photograph of a uniformed officer escorting a protester out. When necessary, it has to be done. But regrettably that captures the notice of the day with an inevitable picture with an officer in uniform and a protester being escorted out, not giving the affirmative impression of a serious congressional panel trying to do something about a very, very serious problem.

But today's demonstration was carefully orchestrated seriatim. So we took the action necessary. I have made it a point in the past, when demonstrators are present, to prolong the hearings from time to time. That will not be now necessary. I think they have said what they came to say. Suffice to say just that.

We are awaiting the arrival of Dr. Helene Gayle, M.D., and in the——

Dr. GAYLE. I am over here.

Senator SPECTER. Well, in the melee, Dr. Gayle, we did not note your arrival.

Dr. GAYLE. They did.

Senator SPECTER. You were not, however, mistaken for one of the protesters.

Now, Dr. Helene Gayle is the director——

Ms. PELOSI. Mr. Chairman, before you introduce Dr. Gayle and Assemblywoman Carole Migden, if I just may seek recognition again, because in cutting my remarks short I did not acknowledge the work of Senator Boxer.

From the first day she went to Congress, elected in 1982, she brought this message there with her about AIDS. Her entire congressional career has been spent working and demonstrating great leadership on this issue.

Senator BOXER. Thank you, Nancy.

Ms. PELOSI. And she has been there for the history of the AIDS epidemic so she knows of what she speaks in this regard.

And also I want to acknowledge the leadership of our mayor, Willie Brown, who would be here except that he is not in town, but the good offices of Bill Barnes from his office was instrumental in making this hearing possible. But kudos to our mayor for his leadership, to our other Senator, Senator Feinstein, who was Mayor through the early part of the epidemic and is a great leader in Congress on this issue.

But Barbara is a special case because she's been there from day one in Congress fighting on this issue.

Thank you, Senator.

Senator SPECTER. Thank you, Congresswoman Pelosi.

STATEMENT OF HON. CAROLE MIGDEN, CALIFORNIA STATE ASSEMBLY

Senator SPECTER. We are going to adjust the schedule just a little bit and we are going to call on Panel One, both Dr. Gayle and Assemblywoman Migden. If you take your seats we are going to hear from you first.

Assemblywoman Migden, I have just been informed that you have commitments, and we are just a little tardy. So we will proceed.

Assemblywoman Carole Migden represents the 13th District in the California State Assembly, first woman and first freshman legislator to share the California State Committee on Appropriations. She began her career in the State Legislature as an advocate for AIDS treatment and prevention. And prior to her election to the State Assembly in March 1996 she served 5 years as a member of the San Francisco Board of Supervisors.

Welcome, Ms. Migden, and we look forward to your testimony.

Ms. MIGDEN. Thank you very much, Senator. And welcome to San Francisco. I know we woke you up this morning.

Senator SPECTER. If you have seen our practice, the green light is to signify 5 minutes, which is the practice of the committee. The yellow comes on at one, and the red is stop.

Ms. MIGDEN. OK. We will move forward; I thank you. And I thank you for coming to our city and your interests and attentiveness to HIV concerns has been something the people of California and San Francisco have been very grateful for. I know you been here before, and we appreciate that.

I am also particularly honored to be joined by Senator Boxer, who has been an advocate and then a vigilant about HIV issues when she was a Congresswoman and has taken that leadership to the U.S. Senate.

Representative Pelosi has been part of the HIV fight for many years ever since she took office in 1988. And the city and California has been well-served by these distinguished representatives. And we are honored to be here before you.

As Chair of the Assembly Committee on Appropriations, Mr. Chairman, I realize the difficulty you face in trying to make the kinds of tough decisions that are being held in balance here. Your task in determining how to distribute precious few dollars to many critical and deserving efforts is, indeed, daunting. I appreciate the challenge of all the public health requests that come before you,

but I am here today to request that HIV prevention programs be given the utmost consideration.

Last year in California, Governor Gray Davis evidenced the commitment of California to HIV funding by appropriating nearly $30 million in State General Fund moneys augmenting last year's allocation by some $10 million.

We are very appreciative that the President has included an additional $50 million for national prevention efforts in this year's Federal budget.

But we are here to say that even though we commend it and we are very appreciative, we need more and more and more to cover the full cost of curbing this disease.

I am here on behalf of the city and county and San Francisco, the people of California to ask that in addition to that $330 million that is earmarked for State and Federal programs I think we need at least $100 million to fortify the prevention efforts nationally. These are the funds that will be used by local and State health departments to start up and effectuate and modernize HIV programs.

This year we want to move towards not just HIV prevention but HIV surveillance programs. We simply have to do more to educate the new populations at risk as the prevalence in location of the disease spreads and changes over the years. As you have heard, of course, there are new population at risk. We are very alarmed by the number of young people that are sero converting. We are alarmed that increasingly women are contracting AIDS.

Whereas, we had safe sex messages that worked for young people, the prevalent population afflicted in our State continues to be gay and bisexual men. And we are concerned because young men aren't getting the message, and that hasn't changed. What's been pointed out is increasingly people of color at target.

Mr. Chairman, that means we have to figure out new ways to deliver a message that is effective, that people understand, that safe sex is an imperative and not only occasionally. We have in many ways hit some cultural limitations as we began a program of prevention of the years ago that needs to be modernized and updated. And that is what we seek these additional funds for.

California is, I think, the most spectacular and diverse State in this Nation. We just hit 34 million people. If we can create and expand upon the model and the know-how and the commitment of San Francisco to replicate nationally I think we'll go very far in curbing this nationwide.

I also want to mention that then Senator Feinstein was the mayor of this city and began that 5-year evaluation program. And really San Francisco has always been on the forefront in determining how to develop really safe sex messages that are effective.

You know, Mr. Chairman, we can figure out how to sell Campbell's soup by advertising. We get manipulated in wonderful ways by advertisements in the media, we buy products, we buy cars. We just wonder if we can apply that same kind of expertise to letting people know the gravest risks at hand.

Lastly, there are costs to California that are unique. We have the largest population of undocumented immigrants. There are 160,000 people in prison in California. Of those 14 percent are illegal immigrants. Not even calculated into these figures are the costs that

California bears by serving in the full range of undocumented people, but most additionally many of these folks in jails have HIV, have hepatitis, have other diseases. And those are also what are seen as indirect but become direct costs to California as well because we are responsible for population that perhaps we need Federal assistance to really treat well.

I know that Governor Wilson was always talking about this. Governor Davis has continued. And this is important to bear note. So we hope that you will be especially generous and responsive to San Francisco.

And as I see my third light, I know that means something.

But to also understand that the money is well used because we have been serious, we have been on the forefront. It was since 1981, and I remember those days. And I was a former county supervisor. I am now a State legislator. All of us here around this dias began at the beginning. And now we know we have gotten the messages to some. New people are at risk. Let's modernized and update. And let's also track where we think those next infections will be, how to concentrate on them——

Senator SPECTER. Ms. Migden, would you sum up, please?

PREPARED STATEMENT

Ms. MIGDEN. I sum up right now, to say, once again, there are nearly 900,000 people in America with HIV. We project that number might stay steady and increase. But Mr. Chair, it will be different people afflicted in the new century. And that is why I think it is important to have these hearings and your understanding of a need for a new approach.

I thank you very much, sir.

Senator SPECTER. Thank you.

[The statement follows:]

PREPARED STATEMENT OF CAROLE MIDGEN

Good afternoon, Chairman Specter and distinguished members of the Committee. My name is Carole Migden and I represent San Francisco in the California State Assembly, where I chair the Committee on Appropriations. It is an honor to appear before you today as we Californians call upon the federal government for help in our struggle against the HIV epidemic.

Mr. Chairman, I am pleased to appear before you today, as your interest and attentiveness to the problems of HIV infections have been tremendously helpful.

And also I am particularly honored to be joined by our distinguished and stellar United State Senators Dianne Feinstein and Barbara Boxer, both of whom were early and effective advocates in our struggle to curb this disease.

Senator Harkin I welcome you to our fine city, your contributions to progressive policies in America are legendary and I am sincerely thankful for your concerns on this pressing health issue.

Rep. Pelosi, I am very glad that you have joined these proceedings today. Your vigilance and leadership on HIV issues has been remarkable in your years of public service.

As the chair of the Assembly Appropriations Committee and as a Member of the Budget Conference Committee, Mr. Chairman and members I realize the difficulty you face in making the kinds of tough decisions before today. Your task in determining how to distribute few and precious dollars that are needed for so many critical and well deserving efforts, is indeed daunting. I appreciate the challenge of endeavoring to address a myriad of public health concerns with limited resources, but I am here today to request that funding for HIV prevention programs be given the utmost consideration.

Last year, California and Governor Gray Davis evidenced our commitment to fighting the HIV/AIDS epidemic by appropriating nearly $30 million in State Gen-

eral Fund revenues for prevention and education. This allocation represents nearly a $10 million dollar increase from the previous fiscal year.

President Bill Clinton too has displayed an unwavering dedication to combating the epidemic and recently announced a landmark initiative to invest an additional $50 million in national prevention efforts. This greatest single year increase for HIV prevention programs will educate hundreds of thousands of individuals who are at great risk of infection.

Yet while these initiatives must be commended and are well appreciated, unfortuately the federal budget falls short of addressing the full cost of funding required to stop the spread of the disease.

Mr. Chairman and members, I am here today on behalf of the City and County of San Francisco and the people of California to request that you augment the $330 million dollars already earmarked for state and local programs by an additional one hundred million dollars to fortify AIDS prevention efforts nationally. These additional funds are necessary so that state and local health departments can start up and effectuate modernized HIV prevention programs. Let me again state our sincere appreciation for the commitment to fighting AIDS reflected in the federal budget, however in fiscal year 2000–2001 an even greater commitment is necessary to fully fund HIV prevention and HIV surveillance programs. We simply have to do more now to educate new populations at risk as the prevalence and location of this disease shifts throughout the nation.

We have gone a long way over the last decades in educating some segments of society about AIDS, but recently we have come to understand that new and differing populations of people are becoming high-risk for HIV infection.

San Francisco is a shining example of what can be accomplished by a local community. The collaboration of medical researchers, state and municipal officials, community organizations and people living with HIV has yielded one of the nation's most comprehensive, state of the art, HIV prevention programs. By virtue of former Mayor Dianne Feinstein's complete understanding of and quick response to the exploding epidemic which was ravaging our city, San Francisco became the first city in the nation to develop a five-year evaluation strategy for HIV prevention, a model of care that the Center for Disease Control still mandates for local and state compliance with federal funding guidelines.

Mr. Chairman and members I cannot overemphasize the tremendous leadership provided at that time by former-Mayor Dianne Feinstein, later joined by Congresswoman Barbara Boxer and Representative Pelosi in their understanding the seriousness of the disease and urgent need for action.

In spite of this unparalleled dedication and know-how, San Francisco and the rest of the nation must increase, renew and refine its HIV prevention efforts with a new and evolving understanding of the different populations and people who will be at risk of infection in the future. The challenges that we face as a nation in our struggle against this epidemic are, have always been, and will continue to be heartbreaking and all consuming.

Mr. Chairman and members, it is an absolute imperative that we educate Americans about the importance of learning their HIV status. There are close to 900,000 people in the United States today living with HIV. Although it sounds hard to believe, nearly a third of these people have no idea that they are HIV positive. Mr. Chairman and members we must do all that we can to educate the public and aggressively encourage all people at risk to go out and get tested.

Here in California, last year our legislature enacted a measure that provides voluntary HIV tests to every pregnant woman in the state. This measure complements our evolving and ever-changing HIV outreach programs today.

Mr. Chairman Specter as you know, the pattern of HIV infection varies from state to state. More and more women, IV-drug users, racial minorities and young people are getting infected today. The federal government must recognize the unique needs of each state in the union, and respond appropriately on a state-by-state basis. Funds must be earmarked for state and local public health agencies to expand community planning, neighborhood outreach, public education using media and town hall meetings if necessary to alert the public of their vulnerability and to stop the spread of the disease.

In light of recent trends of HIV infection, it is clear that our greatest challenge lies in educating young people. American teenagers are becoming sexually active earlier in life, and most are not using condoms. According to the Office of National AIDS Policy two young people become HIV infected each hour. People under twenty-five years of age account for half of the tens-of-thousands of new infections which occur in America each year.

Mr. Chairman and members, the current state of affairs is absolutely unacceptable. This young and high-risk generation of Americans threatens to accelerate the

epidemic just as we were beginning to make progress in our efforts to beat back the disease. New medicines are helping HIV positive people live longer, but in time we've noticed, after years of ingesting highly toxic medications, complications can arise.

We need to adequately fund peer education, group counseling, and other educational efforts targeted at young people. We must reexamine the way we market our prevention efforts, and formulate a message that is appealing and convincing to young people. As the disease changes and progresses we must update and tailor our prevention message for new populations at risk; having safe sex must be seen as a moral imperative.

Mr. Chairman and members in addition to our efforts to connect with high-risk populations, we must at the same time fully commit to funding HIV surveillance programs. The most important thing we can do to stop the spread of the disease is to couple HIV prevention with HIV surveillance.

The California Legislature last year developed an HIV surveillance system to track the rate of incidence of infection and to project and pinpoint the spread of HIV in the future. We designed a surveillance system to identify the location and concentration of new HIV cases and to identify populations likely to be vulnerable in the future. Although Governor Gray Davis expressed support for the policy and goals of the legislation, the bill was vetoed due to lack of funding from the CDC.

Mr. Chairman and committee members, the Center for Disease Control is the preeminent funding source for AIDS and HIV surveillance programs throughout the nation. The CDC has instructed all states in the union to create HIV reporting systems in order to gather updated data regarding the spread of AIDS nationwide. It is imperative that the CDC assist California and all states in their efforts to comply with this important directive.

As I previously mentioned, the State of California increased its funding for HIV prevention programs by nearly $10 million last year. These resources will bolster the CDC's commitment to our prevention programs and aid localities in responding to new HIV infections. New funds are being used primarily to expand programs, which again are targeted toward gays, bisexuals, people of color, high-risk youth and women.

Moreover California has made a significant investment of $1.4 million to monitor and evaluate all currently operating HIV surveillance programs. The funding of program evaluation is critical to ensure that scarce resources are used well and effectively. Furthermore, critical analysis of the efficacy of California's prevention programs will guide the state in making enlightened policy decisions in the future. I am hopeful that the CDC will recognize California's premier role and trailblazing nature by funding these qualitative evaluations of our HIV surveillance and prevention efforts.

Not included in your materials but worth mentioning, is the cost that California incurs each day by serving a large population of undocumented immigrants. For instance there are 160,000 inmates housed in California correctional institutions today. Of those 13.5 percent are illegal immigrants, many of whom suffer from HIV, hepatitis and other acute illnesses.

For many years California has been forced to shoulder these costs alone. Our former Governor Pete Wilson fought long and hard for federal assistance, and Governor Gray Davis is persisting today in urging the Federal government to cover the cost of undocumented immigrants. I bring this up today to draw attention to the great diversity and financial burden California bears in our quest to stop the spread of AIDS.

Mr. Chairman and committee members, in closing, I would like thank you for your compassion and attentiveness to this very grave public health concern. I thank you for using the power of your office to influence and effect our treatment of HIV/AIDS. The people of San Francisco and California have great confidence in your commitment to do all that you can to fight this disease, and we appreciate your willingness to consider our requests for assistance. We know that we can count on you for continued leadership and guidance in the struggle to end this deadly disease. Thank you very much.

STATEMENT OF DR. HELENE GAYLE, M.D., M.P.H. DIRECTOR, NATIONAL CENTER FOR HIV, STD, AND TB PREVENTION, CENTERS FOR DISEASE CONTROL AND PREVENTION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator SPECTER. Before going to the first round of questioning, as a matter of timing for the hearing, I want to turn now to Dr. Helene Gayle.

I hope you can stay, Ms. Migden, for the round of questioning.

Ms. MIGDEN. Yes, sir.

Senator SPECTER. Director of the National Center for HIV Sexually-Transmitted Disease and TB Prevention at the Centers for Disease Control and Prevention, Dr. Gayle also serves as AIDS Coordinator and Chief of the HIV-AIDS Division for the U.S. Agency for International Development. She received her medical degree from the University of Pennsylvania.

Thank you for joining us, Dr. Gayle. And we look forward to your testimony.

Dr. GAYLE. Thank you. I am proud to have been a resident of your State for a few years. I am not currently still the Director of Programs at USAID. That was a previous life. I can only do one job at a time.

It is a real pleasure for me to be here with you. And because my time brief I will not go into as much as I would like to in terms of how appreciative I am to you for your leadership and for being here for this hearing, and for the two of your colleagues, Congresswoman Pelosi and Senator Boxer, who are here with you. I can't say enough about the leadership that both of them have shown in this epidemic and how proud they make me to be a woman.

Let me to start by saying that I think this is an important hearing at a very important time when the issue of investment in prevention is perhaps more important than ever. The AIDS epidemic has changed considerably since it first began in 1981, and many of the data are well-known. We will provide you with kind of an overview of current data.

But we know that the declines in AIDS deaths have been impressive, 62 percent from 1996 to 1998. And the decline in AIDS cases, 29 percent from 1996 to 1998, have also been encouraging. And a lot of this reflects the investment that we have made in research into new therapies and in care and treatment. And so it is encouraging that the new highly-active anti-retro viral therapies have really made a big difference in the lives of people with HIV.

We feel the bottom line is that same sort of investment made in prevention would also yield similar results. We have made a lot of change in new infections. We went from 150,000 new infections in the mid-to late 1980s to approximately 40,000 new infections today. However, that 40,000 new infections is the same number that we have had for several years now.

And we also know that, while the number of new infections has changed, the demographics in the populations affected have diversified and have changed. We know that, for instance, 50 percent of new HIV infections are occurring among people under 25 years of age. Thirty percent of new infections are now occurring among women; 64 percent of those women are African American. Fifty-four percent of new infections are occurring among African Americans and 19 percent among Hispanics. And we published most recently in our MMWR publication that African American and Latino men now represent the majority of AIDS cases among men who have sex with men. So clearly this epidemic is diversifying and the populations are changing.

Our early prevention work targeted the communities most affected. And at the time the populations were primarily gay men

and injecting-drug users. And we also do a lot to make sure that the general population understood about a very new disease that was threatening our society.

As the epidemic has diversified, our efforts have also expanded to include broader audiences, particularly communities of color, gay men of color, people living with HIV, youth, women including pregnant women, people with sexually-transmitted diseases in communities with high prevalence of sexually-transmitted diseases, incarcerated populations as previously mentioned, et cetera.

We know the success of the highly active anti-retro viral therapy is encouraging, but the availability of these new more effective treatments is also leading people to believe that HIV prevention is no longer important. We have a lot of data that show that people are, in fact, engaging in risk behaviors that at one point had become less prevalent.

I won't go into all of the data. They are there in the statement. But, for instance, in a study that was done in San Francisco looking at a time period of 1994 to 1997 increases in anal sex went from 57 percent to 61 percent. Men reporting multiple sexual partners and unprotected anal intercourse increased from 24 percent to 33 percent. And the largest increase in that activity was, in fact, in young men less than 25 years of age. And that was also followed with an increase rectal syphilis.

A study from King County Health Department among men who have sex with men also showed a rapid expansion of syphilis in men who have sex with men from a rate of zero per 100,000 to a rate of 200 cases per 100,000 projected in 1999.

Another study that we did most recently showed that in people at high risk for HIV 31 percent were less concerned about becoming infected with HIV because of the new treatments. And 17 percent said they were less safe about sex or drug use because of new HIV infections.

I won't go on in great detail because I see the red light is on. But I just would say our efforts are continuing to diversify. We are continuing to work with new partners. We understand that our efforts have to work with a broad range a cross-section of society.

We continue to have our community planning process which involves the community in decisionmaking and targeting resources as our main centerpiece for the funds that go through local and State health departments.

However, we have continued to expand and work with community-based organizations, nongovernmental organizations, faith-based organizations, correctional facilities and a variety of other civic and business organizations.

Clearly the good thing about prevention is that we know now more than ever what works, and we will give you a compendium that we have released on programs that work and that we know make a difference. The flipside of that is that we don't feel we are doing enough to make sure that the programs that work get to the populations that need them the most.

We feel a lot of this has to do with a variety of things that keep us as a Nation from moving forward ahead in prevention as we should, things like a lack of resources, AIDS stigma, policies that limit some of the proven public health interventions, lack of female-

controlled options and, perhaps most troubling, the complacency that we are seeing, not only at an individual level, but also had a societal level. I think we have got to work on all those things at the same time that we make sure that we have adequate resources to do the job of really investing in prevention for this nation.

Thank you.

Senator SPECTER. Thank you very much, Dr. Gayle. Your full statement will be made a part of the record, as will Ms. Migden's.

Let me begin with you, Dr. Gayle, on a study which you refer to in your written testimony published in the Philadelphia Inquirer, 2 weeks ago today, on a CDC study of some 1976 people where the results were curious that, "With the new medications people have become less concerned about contracting HIV with the statistics showing 31 percent were less concerned about becoming infected and 17 percent were less careful."

How do we combat that? We certainly do not want to retreat on our efforts to find a drug therapy to combat HIV. So what's your recommendation from CDC, which offered a study?

Dr. GAYLE. Yes. I think what that study says to us is that we have to make sure that we have a balanced approach to this. I think people in our society in general want to find quick easy fixes to health problems. Anytime you are talking about a health problem that requires sustained behavior change that is not a quick, easy fix.

I think when the new therapies were first announced, there were media stories all over that said, "End of the epidemic." And I think people really did start to think that we had found a cure and that HIV was no longer a serious disease.

I think we should be very, very happy that these new therapies have made HIV a much more controllable disease than it was, that it has improved quality of people's lives. But it is still is a very serious disease. It is still life-threatening. It is still costly. The regiments are very expensive and complex. And they don't equate with people no longer being infectious, or they don't equate with HIV no longer being a serious disease.

So I think we have to give people the balanced message that, yes, it is good that we have these better, improved therapies; yes, they have made a difference in people's lives and that should be an encouragement. But we also have to make sure that we have in place services to sustain safe behavior and understand that that is not a one-shot deal, that that is a long-term effort.

We see that in young gay men for instance. We know that San Francisco is a good example where gay men had changed their behaviors. But that was one generation of gay men. We can't assume that you do prevention once and that it's over.

Senator SPECTER. Let me move on to Ms. Migden and come back to you for another question.

Dr. GAYLE. Yes.

Senator SPECTER. We have a limited amount of time with a 5-minute allocation.

You have been on the scene for long while, Ms. Migden, and I would be interested to know if you think there has been any discernible improvement in the San Francisco community as we have very substantially increased the funding in so many directions?

Ms. MIGDEN. Yes, we have because the number of cases projected for next year for HIV conversion, I think, is under 500. And if that is correct for Mr. Barnes, and whereas that still sounds like a striking number, and it is, as I said when the disease originally emerged here it was only from gay and bisexual male behavior. Over the years we realize IV drug addicts were also at risk and women and racial minorities that have added to it. So we have been somewhat successful with an older generation of the first folks afflicted in getting that message across.

I'll tell you what's alarming to me, sir. I think it is important for the government step in. I was concerned when the Ryan White Foundation closed and other charities closed, so we have had difficulty keeping the momentum of interest and the public and the volunteers involved.

I want to just capitalize on something Dr. Gayle said, which are of the 900——

Senator SPECTER. Could you be brief? I want to come back to Dr. Gayle for one more question.

Ms. MIGDEN. One minute.

Of the 900,000 people that are afflicted with AIDS, you know, there's a third or more people that don't even know they have it. So there's a problem with prevention with those that have it that aren't even aware. Let alone, let us direct efforts to those most likely to be at risk.

Senator SPECTER. OK, before my red light goes on.

We have quite a number of programs. And the thought occurs to me is whether we are making it a proper allocation on prevention, versus research, versus pharmaceuticals. And you have quite a number of different agencies at work directing their own specific attention. And perhaps it is a congressional function. Perhaps it is this subcommittee's start to make an allocation.

What is your judgment as to whether there is an appropriate balance in prevention, versus research, versus pharmaceutical application, et cetera?

Dr. GAYLE. Yes. I think to make a difference in all the arenas that we need to make a difference in there needs to be a comprehensive approach. And I think that means that there needs to be as close as possible equal investment in prevention as there is in the other areas. We have not had an equal investment in prevention.

I think it is telling that if you look at the Federal budgets over the years, and if you trace increase in Federal budgets by agencies that work on HIV, and you look at declines in deaths, and declines in AIDS cases, and declines in new infections. New infections have plateaued at the same time that the prevention budget has essentially plateaued and stayed stable as opposed to budgets that relate to research and treatment, which have grown exponentially. And those are where we have had the greatest impact on deaths and new AIDS cases.

So I think while we can't say it is necessarily cause and effect, I think there's clearly a relationship between the investment that you make and the impact that you have on different segments of this epidemic or different components of this epidemic. I think if

we want to make an impact on prevention we need to invest in equal, or close to equal, in prevention.

Senator SPECTER. Thank you, Dr. Gayle.

Senator Boxer.

Senator BOXER. Thank you very much to both our panelists. And I am very proud of the work you do.

And, Carole, for us to have you in such a high position in the State Assembly, we are just very fortunate.

And, Senator Specter, this is a person who is like you in terms of seeing a problem and solving it or trying to solve it. And I am glad that you two got a chance to meet.

I wanted to just point out, given the facts that have laid out in terms of the number of cases and the changing face of AIDS, that anyone who goes around saying, "There's no more AIDS," is doing a tremendous disservice to us. And I don't know if anybody in the audience who wants to yell at me, but bottom line is, you know, it is a little intimidating to have that kind of screaming focused on you. Nancy is much more used to it. But it is just counter-productive, plain and simple.

And when you talk about people saying, "maybe the epidemic is over," it sure doesn't help to have a whole group of people, who I believe are quite well-intentioned, telling people that, in fact, you know, there is no more AIDS.

So we have to say, if nothing else comes out of this particular hearing, we believe that the face of AIDS is changing and we can't take our eyes off the face of it, and we can't take our eyes off the problem.

I have quick questions in my time.

Dr. Gayle, I have also been interested in the issue of the transference of the disease from mother to child in utero. And I worked with the Elizabeth Glaser, Pediatric AIDS Foundation. And we have had a breakthrough with a new drug called Navaripine, which costs $4 to administer this drug as opposed to $80 to administer AZT. I am very excited about it because I feel, if we look at Africa, for example, where this is an enormous problem, but even right here in our country, we could begin to go into areas where there's not a lot of money and we can make difference.

What is your sense? Do you feel as optimistic as I do about this drug? My understanding is it has been proven effective in about half the cases, so we are stopping half the transmission; is that about right?

Dr. GAYLE. Yes. We are very optimistic about our efforts in eliminating pediatric HIV infection in general. We feel that it should soon no longer be a public health problem in this country. We have the means to make it a very, very rare occurrence in this country.

And I think with a combination of what people already use, the AZT protocol and perhaps some of the newer therapies like Navaripine. I think we are too soon yet. We only had a couple of studies of Navaripine. I think it is important to make sure that there are no long-term consequences in some of the other things.

But we do know that, while we have had a tremendous decline in the number of new pediatric AIDS cases, 75 percent decline over the last few years, tremendous because of the AZT given to pregnant women, the women who are remaining who are likely to

transmit HIV to their children are women who come late in prenatal care so that they aren't able to take advantage of the typical AZT course which starts earlier on in pregnancy. So what we are doing is actually looking at women who present to delivery rooms without knowledge of their status the ability to actually get their HIV status then and then give them something like either AZT or Navaripine at that point in time. So we are really looking at how can you tailor these therapies currently to the women at greatest risk, those who don't have good access to prenatal care.

Senator BOXER. Well, thank you, Dr. Gayle. I am——

Dr. GAYLE. And clearly for Africa and developing countries we are looking at that issue where that is even more of an issue.

Senator BOXER. Yes. I mean, it just seems to me this is an area of progress, we should all be happy that we have this breakthrough.

Dr. GAYLE. Exactly.

Senator BOXER. Let me ask you, Assemblywoman Migden, in the remainder of my time, a quick question.

I know that you have legislation which would establish a unique identifier system for California. Could you explain to us the problem we have with reporting and how your bill would help and how I can help you with that?

Ms. MIGDEN. Thank you very much, Senator Boxer.

The CDC, of course, has instructed all States to develop a surveillance plan either by using names or unique identifier codes. We worked very hard to craft legislation last year that made it to the Governor's desk. He supports the policy of a unique identifier code. This is controversial. The State of Maryland uses a unique identifier. That is, identifying patients by numbers as opposed to by names.

This, of course, is terribly important because we don't want to dampen the willingness of people at risk to come get tested as this would affect gay discrimination. We felt that that would hinder our efforts to get a collection. This has nothing to do with notifying partners. All those systems are well in place.

The Governor asked us to work this year on the budget to identify $2 million which he hopes will be forthcoming from CDC for purposes of instituting a unique identifier system and have our HIV surveillance program in place.

I also just wanted, a little point, that we had a piece of legislation last year that passed that gave HIV tests voluntarily to pregnant women. I know you had a concern, and that is something that California stepped forward with at first.

Senator BOXER. Good. Thank you.

Senator SPECTER. Thank you, Senator Boxer.

Congresswoman Pelosi.

Ms. PELOSI. Thank you very much, Senator Specter.

What a wonderful start of our official formal part of this program. Because how well we are served in our community by having Assemblywoman, Chairwoman Migden as Chair of the Appropriations Committee in her first term. That's pretty remarkable. That is impressive. And she knows this issue chapter and verse sadly and the issue is well-served by her leadership there.

And Dr. Gayle, it is a family affair for her in terms of international leadership. She and her brother Jacob have played in all of this and in prevention, of course, at CDC. Dr. Gayle, we all are greatly in your debt.

I just want to ask a couple really quick questions. But following upon something you asked, Senator Specter, about how are things in San Francisco. We have been a model for responding to this epidemic. So many people who are diagnosed elsewhere come here. Therefore, they are not in the formula for the money that we get for the Federal Government.

I just wanted to point that out to you because when people are talking about formulas and holding us harmless, and the rest, you have to recognize that we are carrying, we are doing a lot of heavy lifting for other parts of the country where again, people are diagnosed, but they come here. So this is a very controversial issue even in our own State. And I wanted to point it out to you.

In terms of people not using behavioral patterns that would be in furtherance of their good health, we found that people who have a low level of HIV infection will not develop AIDS. And this again contributes a little bit to the recklessness of people then going on and being engaged in unsafe sex. And then also we find that young HIV-positive people are more than twice as likely as adults to continue engaging in risky behaviors. So the need for prevention is very, very great.

The scientists among us had a conference, a retro virus conference, here a week or so ago. And what they found was that oral sex may be riskier than thought. And the study reported 8 percent of the 102 cases surveyed of HIV infection among gay and bisexual men is likely due to receptive oral sex without a condom. We must provide funding to help people understand this concept in the research.

I bring that up because I want to put it on the table for our two witnesses. This prevention has to be very, very frank.

Dr. GAYLE. Yes.

Ms. PELOSI. I mean, we can't mince our words on this. The same retro virus conference findings demonstrate a resurgence among unsafe sex, among gay men. They are exhausted about worrying about this for years. And so the need for more money for prevention, I am glad the administration finally put more money in, because they always left it up to Congress to do that. But I still don't think there's enough in the budget.

But separate from the money is the frankness, the candid, specific to an area. What works here may not work in Iowa, or Newark, but nonetheless we have to save lives.

So I would invite our two witnesses to say how receptive you think the State of California would be, or federally, to the frankness of the message that we must put forth if, for example, we are talking about oral sex and how much more at risk people are who engage in that without a condom?

Ms. MIGDEN. I think we Californians, and as you see, are pretty forthright—we started off with accepting those messages. You know, Congresswoman Pelosi, something you know because we really started to mark the epidemic here in the Bay Area, what we found sadly, Senator Specter, is that some young gay people felt

they got more support in society when they were zero positive than when they were just identified as gay people or individuals discriminated by society. So in a very odd away there was some counter-current forces working that perhaps made one feel that they are part of a charity, you see, and didn't encourage enough safe sex.

The thing with safe sex, as Congresswoman Pelosi knows, we are saying every single time has to be a certain way. So I think we have to continue to be frank and forthright. I also think we have to modernize our messages because, you know, what's called the Gen Y generation now looks at things a little differently than several sets of generations did years ago. I think there are people and young people that call for candor and straightforwardness, and I believe we support that.

The HIV surveillance part I think that is important is to know your status kind of campaign and that we begin to address and make sure that everybody gets tested. And the money we are seeking here is to keep it on a grassroots level. Come in, get tested and know where you are.

There were jobs discriminations' protections passed last year by Governor Davis that says can no longer be fired from a job because you are a gay man or a lesbian. That will help maybe even in encouraging to come forward and get tested.

But sadly I just want to make the point that, you know, in societal moves the discrimination certain groups face, and this isn't exclusive for lesbians and gay men, it affects minority groups and others, people who feel outside of the process or went down through the process, sometimes feel more buoyed, and more welcome, and more mainstreamed, when they're sick they get sympathy, and when they are healthy they are outlaws or outsiders.

Dr. GAYLE. Yes. Just briefly, since the red light is on. I think it is important, the point about the ability to do what we know can make a difference is a high priority for us. I think while the resources aren't always an issue the ability to put in place sound science-based prevention programs is critical. I think that there are oftentimes policy impediments to doing that.

For instance, we know from all the evidence and from all the studies that talking the children about sex doesn't encourage sexual activity. It, in fact, does the opposite. It encourages young people to have responsible sexual activity and often to delay sexual activity.

However, there are many people who would suggest that talking to young people about sex is not a good thing, and that it actually encourages sexual activity.

So there are examples like that. And I could go on and on about examples where we know what the science tells us about what can make a difference in preventing the spread of HIV where, because of policy challenges, if you will, we are not able to totally implement that. So I think it is an important issue. We need to be able to speak openly and honestly about this disease, how it is transmitted, who it affects. And unless we can do that, I think we will not be as successful in preventing the further spread.

Ms. PELOSI. Thank you, Dr. Gayle.

I thought you were going to mention needle exchange there for a minute, because we know the science is there for prevention there, as well.

Dr. GAYLE. I'll let you mention that.

Ms. PELOSI. And one of the reasons why we have almost zero transmission from a mother to child is the success of our needle change program here.

The red light is on. Thank you, Mr. Chairman.

Senator SPECTER. Thank you very much, Congresswoman Pelosi.

And thank you, Assemblywoman Migden and Dr. Gayle.

When where you at Penn, Dr. Gayle?

Dr. GAYLE. I am sorry?

Senator SPECTER. When were you at the University of Pennsylvania?

Dr. GAYLE. I finished in 1981.

Senator SPECTER. 1981?

Dr. GAYLE. Yes.

Ms. PELOSI. When did you finish, Senator?

Senator SPECTER. I haven't finished.

Dr. GAYLE. Thank you very much, sir.

Senator SPECTER. Representative Migden, before you leave, one final question as you depart. I am very much impressed that you are the chairperson at 3½ years into your term. And I am interested in your reaction—although you may have a bias—not that that would be unusual for any of us—on term limits. One of the lead stories in the New York Times this morning is what's happening in term limits throughout the country with some focus on Ohio.

And I just wondered if you would mind commenting for the record what you think about it, aside from your rapid rise? I would like to tell Strom what you think when I get back to Washington.

Ms. MIGDEN. You tell the great Senator that he's safe. I oppose them, sir. And without question it gave me a wonderful opportunity. And I think that is true of many of the newcomers.

What I fear and what I am seeing, sir, in the State House is there's just a loss of expertise and too much concentration on campaigning. I run a 2-year term and a maximum of 6 years of service allowed. So I don't think we develop the expertise and wealth of knowledge that is necessary to really serve people well from a macro, long-term perspective.

In California now we are trying to repair our schools. They have been in disrepair for 20 years. Different sets of us will struggle. But I fear that long-term really courageous solutions will be put off because there's really very little incentive to kind of be bold, step out, do something controversial and also have the time you need for follow-through.

I am realizing that it takes a good set of years to get legislation forward. Last year, some that I really cared about, which took 3 years. And I think that unfortunately it is going to detract from the caliber of representation.

If one is a young person and wants to come forward to take a job, a 6-year job, then one is unemployed, I think the best and brightest might find other careers for a long-term security.

However, having said that, it is exciting to serve with new faces and personalities and people and having the enfranchisement and excitement of the great diversity of California. But I don't think it is good policy for the people of California.

Senator SPECTER. Thank you very much, Madame Chairperson.

Ms. MIGDEN. Thank you very much, sir.

Senator SPECTER. That's quite a statement coming from the chairman.

Ms. MIGDEN. Thank you very much.

Senator SPECTER. Thank you.

Thank you for coming, Barbara.

STATEMENT OF DOROTHY MANN, CHAIR, GOVERNMENT AFFAIRS COMMITTEE, AIDS ALLIANCE FOR CHILDREN, YOUTH, AND FAMILIES

Senator SPECTER. We now turn to our lead witness Ms. Dorothy Mann, Board Member of the AIDS Alliance for Children and the Executive Director of the Family Planning Council in Philadelphia. In her capacity as Executive Director she oversees programs to prevent teen pregnancy, HIV infection and other sexually-transmitted diseases; past President of the National Family Planning and Reproductive Health Association and serves on the Allen Marker Institute, Board of Directors. She holds degrees from Bennington College in Vermont and Columbia University and is a long-standing personal friend of mine.

Dorothy, we thank you especially for coming. And in light of the fact that your mother just passed away, we know it is a sacrifice.

Ms. MANN. Thanks.

Senator SPECTER. And we thank you for being here and look forward to your testimony.

Ms. MANN. Thank you, Senator, only for this issue and for you.

As the executive director of the Family Planning Council my program serves over 107,000 of Senator Specter's constituents in Philadelphia. And in addition to our Family Planning Program, as he mentioned, we get with funding from CDC and HRSA, the Family Planning Council provides a range of community-based HIV and STD prevention screening and treatment programs.

I am also chair of the Government Affairs Group of the AIDS Alliance for Children, Youth and the Families. And I am also on CDC's HIV/STD Prevention Advisory Committee.

I have personally known, Senator, about your real concern for AIDS since 1987 when I joined you and Eartha Isaacs for a visit to the AIDS program for children at Saint Christopher's Hospital. Following that visit you became the leading advocate in Congress for what is now known as title IV of the Ryan White CARE Act. Today title IV supports comprehensive HIV care projects for children, youth and families across the nation, including a program in Philadelphia that is based in my organization. You have also supported the entire portfolio of Federal AIDS prevention, care and research programs, and made increases in those programs possible.

And I would also like to acknowledge Congresswoman Pelosi, who has been a tireless crusader on behalf of people at risk for and living with HIV.

We are gathered here because our Nation has become complacent about the AIDS epidemic. As a direct result of the Federal invest-

ment in AIDS research and care programs, many people with HIV are healthier and living longer. Some of those babies, Senator, that you visited at Saint Christopher's hospital back in 1987 are teenagers now. In fact, that program now serves 25 teenagers who were born with this virus.

The news about the success of new treatments has led many people, including those from high-risk groups, to become less concerned about becoming infected and are more likely to engage in risky behaviors. This is a complicated problem with no easy solutions.

Four points:

(1) Prevention to efforts must significantly increase their focus on HIV-positive people.

HIV is spread from an infected person to uninfected person. But we have focused our efforts almost exclusively on uninfected people and have largely ignored those who are already infected.

I am a member of the Community Planning Group in Philadelphia. In 1999 our prevention plan, which was submitted to CDC, in that plan out of every $100 that is spent on HIV prevention only $2.84 is directly used and designated towards HIV-positive people.

Let me be clear. I am not advocating laws or policies that criminalize or stigmatize HIV-positive people or their behavior. I am talking about interventions that help HIV-positive people reduce their risk behaviors and protect their partners from infection.

CDC must have additional resources to address the specific prevention needs of HIV-positive people. CDC is currently funding five demonstration projects, including one in San Francisco, that focus on HIV-positive people. And I would encourage you to consider devoting an additional $10 million through the community planning process for this very important initiative.

In addition HRSA should encourage Ryan White CARE Act-funded programs to bring prevention into the care setting. Among the titles of the CARE Act, Title IV has had the most emphasis on integrating HIV care and prevention.

In our program in Philadelphia reproductive health specialists seek every HIV-positive woman to provide contraceptives, screening and treatment for STDs and counseling regarding HIV and STD prevention. This kind of integrated approach should be replicated throughout the CARE Act.

(2) HIV prevention must be integrated with STD family planning and other related programs.

We have to coordinate these programs. We have to integrate these programs and get over the funding barriers. And we have such a demonstration project in Philadelphia because there was report language in the fiscal year 1999 appropriations bill that allocated $1 million to demonstration projects to integrate HIV, STD and family planning services. And we do this in cooperation with our sister council in Pittsburgh.

(3) HIV prevention programs and policies have to be evidence-based.

We talked earlier about the enormous reduction, 80-percent reduction in perinatal transmission of HIV. That's because we had science, we implemented it, and it works. Last year in Philadel-

phia, Senator, there were four infants born who were HIV-positive out of the almost 10,000 births in our city.

(4) I'll mention needle exchange. Science-based policy needle exchange is not back. It is exactly the opposite. Here we have politics getting in the way of science. It's unacceptable. And we have to finally invest our Federal resources wisely. As a member of the HIV/STD Advisory Committee, I can assure you that any additional funds given to CDC for prevention will be spent wisely.

Frankly, if we were in a war, if we were in a real war against HIV, 40,000 casualties a year would not be acceptable if we were in a real war. So that leads me to the conclusion that this isn't a real war against AIDS. We have got to do more. We have got to do it smarter. And there are all kinds of people like me across the country willing to help you.

Thanks.

Senator SPECTER. Thank you very much, Dorothy, for that very provocative and important testimony.

[The statement follows:]

PREPARED STATEMENT OF DOROTHY MANN

Chairman Specter and members of the subcommittee, good afternoon. My name is Dorothy Mann, and I am Executive Director of the Family Planning Council serving over 107,000 of Senator Specter's constituents in Philadelphia and the four surrounding counties. In addition to our Title X funded family planning services, with funding from CDC, HRSA, and other public and private sources, the Family Planning Council provides a range of community-based HIV and STD prevention, screening and treatment services.

I am also Chair of the Government Affairs Committee of AIDS Alliance for Children, Youth & Families, formerly known as AIDS Policy Center. AIDS Alliance is a national organization that addresses the needs of children, youth and families who are living with, affected by, or at risk for HIV and AIDS. It is also my honor to belong to the HIV Community Planning Group in Philadelphia and the CDC's HIV/STD Prevention Advisory Committee.

Senator Specter, I would like to begin by thanking you for your extraordinary and ongoing commitment to AIDS. Through your leadership, you have demonstrated that the HIV/AIDS epidemic rises above politics. It's a crisis that we all face, and we all must be part of the solution.

I have personally known about your real concern for AIDS since 1987, when I joined you and Eartha Isaacs for a visit to the AIDS program for children at Saint Christopher's Hospital in Philadelphia. Following that visit, you became the leading advocate in Congress for what is now known as Title IV of the Ryan White CARE Act. Today, Title IV supports comprehensive HIV care projects for children, youth and families across the nation, including a program in Philadelphia that is based at my organization. You have also supported the entire portfolio of federal AIDS prevention, care and research programs, and made funding increases for these programs possible.

I would also like to recognize and thank the other national leaders in the fight against AIDS who are here today, including Senator Boxer. Last, but certainly not least, I would like to acknowledge Congresswoman Nancy Pelosi, who has been a tireless crusader on behalf people at risk for and living with HIV/AIDS.

I always welcome an opportunity to travel to San Francisco. But today is not a happy occasion. We are gathered here because our nation is becoming complacent about the AIDS epidemic.

As a direct result of the federal investment in AIDS research and care programs, many people with HIV are healthier and living longer. Believe it or not, some of those babies you visited at Saint Christopher's back in 1987 are teenagers now. In fact, that same program now serves 25 teenagers who were born with the virus. If it were not for the powerful new treatments for HIV disease, many of these extraordinary young people would not be alive today.

Unfortunately, news about the success of the new treatments has led many people, including those from high-risk groups, to become less concerned about becoming infected with HIV and more likely to engage in risky behaviors. This trend threatens to reverse much of the progress that we have made in fighting the epidemic.

Can we turn back this rising tide of new infections? I believe the answer to this question is yes. But it will require bolder leadership, increased funding, and smarter allocation of our resources.

This is a complicated problem with no easy solutions. In the few minutes I have, I would like to focus on four specific points:

(1) The prevention effort must significantly increase its focus on HIV-positive people.—It goes without saying that HIV is spread from an infected person to an uninfected person. But we have focused HIV prevention efforts almost exclusively on uninfected people, and we have largely ignored those who are already infected.

As I have mentioned, I am a member of the HIV prevention planning group in Philadelphia. In the 1999 prevention plan that we developed and CDC approved, HIV-positive individuals are not designated as a priority population. In fact, out of every $100 that is spent on HIV prevention in Philadelphia, only $2.84 is directed specifically towards HIV-positive people.

Ignoring the prevention needs of HIV-positive individuals has led to serious consequences. There is mounting evidence that as people with HIV are living longer and more active lives, they are more likely to engage in unprotected sex. I understand that the San Francisco Department of Public Health recently determined that, in this city, you are most likely to have gonorrhea if you are an HIV-positive man who has sex with men, if you are on combination therapy for HIV, and if you have a high CD4 count. If these HIV-positive men are getting gonorrhea, that means they are having unprotected sex that can also result in HIV transmission.

Let me be clear: I am not advocating laws or policies that criminalize or stigmatize HIV positive people or their behavior. I am talking about interventions that help HIV-positive people reduce their risk behaviors and protect their partners from infection.

What can be done about this problem? We must work to break down the walls between HIV prevention and care programs. Federal agencies, including HRSA, CDC, and SAMHSA must work collaboratively to reduce these barriers.

CDC must have additional resources to address the specific prevention needs of HIV-positive people. CDC is currently funding five demonstration projects, including one here in San Francisco, to focus on prevention with HIV-positive people. This is an important step in the right direction. I would encourage you to consider devoting an additional $10 million through the community planning process to expand the scope of the current sites and add six additional sites. I would love for Philadelphia to be able to compete for some of this funding. I would also encourage CDC to identify best practices in prevention for HIV-positive people and work with community planning groups to implement these programs.

In addition, HRSA should encourage Ryan White CARE Act-funded programs to bring prevention interventions into the care setting. Among the titles of the CARE Act, Title IV has had the most emphasis on integrating HIV care and prevention. At my Title IV project in Philadelphia, for example, reproductive health specialists see every HIV-positive woman in care to provide contraceptives, screening and treatment for STDs and counseling regarding HIV and STD prevention. This kind of integrated approach should be replicated throughout the CARE Act programs.

Finally, I must emphasize the importance of efforts to increase the number of HIV-positive people who know their HIV status. It is estimated that between one-third and one-half of HIV-positive people do not know that they are infected. We need to expand access to and participation in testing so that these individuals can be linked to comprehensive care that includes HIV prevention.

(2) HIV prevention must be integrated with STD, family planning and other related programs.—Just as we must eliminate the artificial barriers between HIV prevention and care, we must also take down the barriers between HIV prevention, STD prevention, and family planning programs. HIV, STDs, and unintended pregnancy are all inter-related, and affect many of the same populations.

We must begin to coordinate campaigns to prevent HIV, STDs, and unintended pregnancy so that we are sending consistent messages about sexual health. We must also move toward a more integrated, consumer-oriented model of services. A teenage girl who walks into a family planning program should be offered HIV and STD counseling and testing, and linkage to treatment if needed. Similarly, if she seeks treatment for chlamydia at an STD clinic, she should receive family planning services and HIV counseling and testing.

Because of report language in the fiscal year 1999 HIV appropriation, there are new efforts underway to make this type of service integration a reality. CDC has allocated $1 million to demonstration projects to integrate HIV, STD, and family planning services and messages. The Family Planning Council in Philadelphia in cooperation with the family planning program in Pittsburgh, is one of these dem-

onstration project sites. I urge the subcommittee to allocate at least $2 million in additional resources to CDC for the purpose of expanding this important initiative.

(3) HIV prevention programs and policies must be evidence-based.—In 1994, when research showed that treatment with AZT could help reduce the rate of mother-to-infant HIV transmission, the public health system mobilized quickly to implement these findings in the field. As a result, the number of babies born with HIV has declined by about 80 percent over the past eight years. Out of the approximately 10,000 babies born in Philadelphia last year, only four were HIV-infected.

But our success in implementing research findings on perinatal transmission has been the exception to the rule. Clinical and behavioral HIV prevention research has yielded many important findings about what does and does not work, but this knowledge has not always made it to the front lines of the epidemic. Additional resources should be given to CDC, HRSA and other agencies to significantly increase the investment in training and support to programs and communities to facilitate technology transfer from research to practice.

Scientific evidence should also be the basis for HIV prevention policies. Unfortunately, that has not always been the case. Politics has stood in the way of implementing HIV prevention strategies that have been scientifically proven to work. For example, research has shown that needle exchange programs reduce HIV infections and do not increase drug use. Yet there are federal restrictions on funding for these lifesaving programs. If we are to wage an all-out war against HIV, we cannot allow politics to take precedence over science.

(4) Federal resources must be allocated wisely.—Reinvigorating our nation's HIV prevention efforts will require a larger federal investment in prevention. With the exception of some special funding from the Congressional Black Caucus initiative, federal HIV prevention programs have essentially been flat-funded for years now. To his credit, the President has requested a $40 million increase in fiscal year 2001 to expand local HIV prevention efforts, including interventions targeted toward people of color, and to expand the "Know Your Status" campaign. This request is an important start, but it is not enough. I urge the subcommittee to exceed this requested amount. I would recommend that a significant portion of this additional increase be devoted to the three areas I have discussed: expanding interventions for HIV-positive populations; establishing additional demonstration projects to promote integration of HIV, STD, and reproductive health services, and enhancing training which is designed to bridge HIV prevention research and practice.

We must also invest more in programs such as substance abuse prevention and treatment, family planning, and STD prevention. An increase for these programs can contribute to our overall ability to reduce HIV infections. Science has already shown that STD prevention can make a major contribution to the decreasing the spread of HIV.

We are all aware that there have been fiscal management and accountability problems at CDC. But I would urge you not to withhold increases for HIV prevention because of these concerns. This year, the CDC HIV/STD prevention advisory committee, of which I am a member, convened a working group to conduct an internal review of the budget and priorities of the Center on HIV, STD and TB Prevention. Under the leadership of Dr. Gayle, with input from the Advisory Committee, this process will continue to assure that the Center is allocating its resources wisely and effectively. I am very confident that any new resources appropriated by the Congress for HIV prevention will be well spent.

Let me leave you with a final thought. Reversing the nation's growing complacency about AIDS is a daunting task. But we must do more—much more—than simply prevent an escalation in the HIV infection rate of 40,000 new cases each year. Forty thousand infections, over 100 per day, is intolerable. Do we really have a war on AIDS in this country? If we had 40,000 American casualties in a war, would we find that acceptable? I hardly think so. The time has come for us to muster the energy, resources and courage to truly end the spread of this terrible epidemic. Thank you for your time. I will be happy to answer any questions that you may have.

STATEMENT OF THOMAS J. COATES, Ph.D., DIRECTOR, CENTER FOR AIDS PREVENTION, AIDS RESEARCH INSTITUTE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Senator SPECTER. We now turn to Dr. Thomas Coates, Professor of Medicine, Epidemiology and Bio Statistics at the University of California here in San Francisco. He also serves as Director and Principal Investigator of the Center for AIDS Prevention Studies and Director of the AIDS Institute at the University. He was

among the first behavioral scientists to conduct research on HIV prevention. B.A. from San Luis Rey College, California. Master's Degree from San Jose and a Ph.D. from Stanford.

Thank you for joining us, Dr. Coates. And we look forward to your testimony.

Dr. COATES. Thank you, Senator and Congresswoman Pelosi.

I would like to start with an apology. Although we in San Francisco do disagree vehemently with each other it is never acceptable to cast aspersions on anyone, however vehemently we disagree with them. You do not deserve what was said to you, and I apologize for that. You have been champions in this epidemic, and we thank you.

I also want to thank you especially for what you done at NIH. The AIDS story is a real success story. And it is because of the investment in HIV. We have identified the virus. We have taken the virus apart. We are understanding how it works, and we have made great progress.

As Congresswoman Pelosi mentioned we did host the Retro Virology Conference here. It's the most esteemed scientific conference devoted to HIV and AIDS in the world. And there was a lot of good news coming out of that conference, but there were two pieces of grim news. And the first piece of grim news is that progress toward a vaccine is very, very, very slow. And the reason is not hard to understand.

Every successful vaccine that modern medicine has made has been for a disease for which we have natural immunity. With HIV we need to learn how to invent immunity. We don't know yet how to do that. But once we learn how to do that it will have implications, not only for HIV, but for a lot of other viruses and a lot of other bacteria for which we don't have natural immunity. So the investment is worthwhile, but it may be one, two, maybe three generations before we really get a vaccine. So that means prevention is here and we're also in the long haul.

On November 30, 1999 I sent a letter to President Clinton. And with your permission I'd like to have it entered as part of the record.

Senator SPECTER. Without objection it will be entered.

[The information follows:]

LETTER TO PRESIDENT CLINTON

UNIVERSITY OF CALIFORNIA SAN FRANCISCO,
San Francisco, CA, November 30, 1999.

Hon. WILLIAM J. CLINTON,
President of the United States,
Washington, DC.

DEAR MR. PRESIDENT: I am writing to present for your consideration a 10-point plan that, if enacted, would cut new HIV infections in the US by half. Enacting this bold but realistic plan to save lives could be the defining legacy of your leadership on HIV and AIDS.

The Center for AIDS Prevention Studies (CAPS) at the University of California, San Francisco (UCSF), which I direct, is the largest research project in the world dedicated to the scientific understanding of HIV prevention. Just as our investments in biomedical research have yielded important new AIDS therapies, so too has our work in prevention science-largely supported by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC)—yielded evidence-based prevention programs known to be effective in limiting HIV transmission. In

short, we now have a broad array of scientifically validated, evidence-based prevention tools that—if implemented—can stop new infections.

This nation is at a critical juncture in its response to AIDS. Although new treatments have allowed more people to live longer with HIV and AIDS, those advances may be cause for concern as well as hope. Improved survival has led to a growing and deadly complacency toward the disease, as well as to more individuals capable of transmitting the disease living active lives. With the rate of new infections actually increasing within many communities, the time to employ our knowledge and prevent new infections is now.

1. TAKE LEADERSHIP

Your administration knows how to take leadership on key issues. Apply the same zeal to HIV prevention as you have to increasing the numbers of police officers on the streets and teachers in the classrooms. Expect results from your health leaders. Talk to the nation. Push for funding and sound laws. Fight intolerance and stigmatization. Take charge of a newly invigorated national campaign to stop AIDS.

2. ESTABLISH NATIONAL GOALS

Articulating bold national goals serves to raise expectations and mobilize efforts. Strong goals can serve as compass points for our national efforts and help direct policy changes that need to be made. Tell the nation that your Administration is committed to cutting the infection rate in half in three years, to increasing the access to treatment for those living with HIV and AIDS, and to helping those who are already infected but don't know it, to get tested. Reducing new infections by half is entirely possible, but will not be easy. Your Administration needs to provide strategic direction, ensure national coordination, and demand results.

3. DEVELOP A RESULTS-ORIENTED ADMINISTRATION-WIDE STRATEGIC PLAN FOR PREVENTION

Your Administration lacks a coherent strategic plan on AIDS prevention. Funding decisions are often made agency-by-agency-and sometimes division by division-rather than in a more effective and coordinated manner. An Administration-wide strategic plan is necessary to guide the prevention process, establish measurable outcomes, insure coordination, and enhance accountability. This Plan must carry with it a mandate for implementation from you, as well as an annual review process to determine the extent to which the plan had been carried out. Such coordination should include the linkage of all HHS agencies (especially CDC, SAMSA, and HRSA) as well as others in the Departments of Justice, Housing and Urban Development, and Education.

Establish an HIV prevention bypass budget. Under your leadership, the Office of AIDS Research (OAR) at the National Institutes of Health has provided a model for developing budget priorities for HIV/AIDS research. This model involves the development of a budget that implements a multi-year strategic plan and bypasses normal agency and departmental reviews. Such a process helps integrate the prevention campaign throughout the public health system and encourages the promotion of a budget that reflects true need.

Your public health leaders must make AIDS prevention a primary focus. It is absolutely essential that the Secretary of HHS and the Director of the CDC develop the leadership necessary to forge a visible, visionary HIV/AIDS prevention policy that is politically viable and grounded in sound evidence-based programs and policies. Strategic planning and implementation at the CDC, which must be the lead federal agency in this effort, need substantial improvement. HIV prevention resources are fragmented, are used disproportionately for CDC infrastructure, and are not mobilized to address the changing needs of a dynamic epidemic. CDC must be supported to lead this effort, and it must also be held accountable for its success.

4. ESTABLISH NATIONAL STANDARDS OF PREVENTIVE SERVICES

An essential step in our efforts to utilize the new treatments has been the establishment of "standards of care," HIV treatment standards that should be followed to insure the best medical result.

We must treat prevention with the same seriousness. HIV prevention is a scientific effort; years of research and investment by the NIH and CDC in the area of prevention science have resulted in an array of effective prevention interventions. The evidence is in. What is needed now is a national effort, perhaps led by the Surgeon General, to define "prevention standards of care" that clearly establish the minimum standards of prevention services that each at-risk person should receive.

In turn, that will help guide our public health system to do all that it can to implement those standards and thereby prevent new HIV infections.

5. COORDINATE MULTI-TIERED NATIONAL EFFORTS

You, as our nation's leader, must bring in and challenge the private sector to be a more active partner in our AIDS prevention efforts. You must also fight with us to free our prevention efforts from the stultifying influence of politics on public health, especially with regard to restrictions on advertisements in the media. National media campaigns on issues such as "Talk to your children," "Know your status," "Stop the Hate, Stop the Fear," and "Prevention works" could go a long way toward advancing the cause of HIV prevention. Providing a Presidential-level forum for business leaders, public health officials, and community and scientific leaders would change the discourse around prevention and provide support for an effort based on sound public health science and not on politics.

6. INSURE THAT RESEARCH IS USEFUL TO PLANNERS AND PROVIDERS

Close coordination on prevention research between the NIH, the CDC, HRSA, and SAMHSA will help translate research into practice. Working together, these agencies can identify gaps in our prevention knowledge, design and implement research programs to fill those gaps, and disseminate the research results in a useful format to those doing prevention. We do not have the luxury of time or resources to be doing research that is strictly academic. Our efforts must focus on answering the critical questions of serving those in need with effective prevention services.

Establish centers of excellence. Mechanisms are needed to link prevention scientists to community planners. We suggest designating current prevention research centers like those in Connecticut, New York, Wisconsin, and California as HIV Prevention Centers of Excellence. With increased support, these Centers could reach out to community planning groups, health departments, and community organizations and help them craft evidence-based prevention campaigns. In addition, funding to academic and community organizations should be used to enhance two-way transfer of skills and knowledge as well as community collaborative research by mandating partnerships between academicians and practitioners.

Share knowledge of proven prevention methods. Our substantial investments in prevention science research are of little value if they are not shared with those that are doing prevention work. Too often, recipients of federal prevention support are not provided with this critical information, nor are they required to focus their efforts on proven interventions. CDC and other agencies must make more vigorous efforts to insure that evidence-based approaches to HIV prevention are identified, publicized, and disseminated to health departments and community based organizations in an accessible format.

Increase the impact of minority researchers. There are too few prevention scientists from those communities of color most impacted by this epidemic. More aggressive efforts are needed to recruit and sustain minority researchers. In addition, that research which is being provided by African-American, Hispanic, Native-American and Asian-American investigators must be made available to their respective communities in a more timely way.

Adapt evidence-based research programs to local community needs. Research is needed on improving our ability to rapidly adapt prevention science findings in different populations or in different communities—no single approach works everywhere, so local epidemics need locally specific prevention solutions. Evaluations are needed to monitor the effectiveness and cost-effectiveness of various interventions and to improve technology transfer so that effective interventions can be implemented.

7. REDESIGN SURVEILLANCE SYSTEMS TO SERVE LOCAL COMMUNITY EFFORTS

To date, the bulk of our AIDS surveillance efforts have focused on case-based reporting. There has been considerable discussion of late on the need to expand our HIV surveillance efforts since AIDS-related data provide only a partial picture of this nation's epidemic. Unfortunately, the debate has focused on whether named reporting or unique-identifier reporting systems will be utilized. In fact, neither mechanism for HIV case reporting can provide the information needed for effective HIV prevention planning at the local or national levels.

Instead, we must build surveillance systems that use research sampling techniques to better estimate HIV incidence, as well as the expansion of population-based sentinel surveys, the expansion of behavioral surveillance, and the improvement of the monitoring of drug resistant strains of HIV. New technologies offer significant promise in our ability to increase voluntary HIV counseling and testing and

our understanding of the timing of the actual infection. The systems in place must reflect such capabilities and be focused on providing community HIV prevention planning groups with accurate and timely epidemiological data.

8. EMPOWER COMMUNITIES TO IMPLEMENT EVIDENCE-BASED PREVENTION

Increase local funding. Communities across this nation have been unable to do the planning and service provision needed because they lack adequate funding. Just as in the areas of education and law enforcement, to ramp up our AIDS prevention efforts we must increase our investments. We must expand priority interventions targeting groups at increased risk, respond quickly to emerging risk groups, increase our prevention services for persons already living with HIV, and support safe behaviors through prevention case management.

Evidence-based community planning should be used to distribute new funds. As with so many issues, effective local planning is at the core of an effective prevention campaign. The AIDS epidemic in the US is actually a collection of smaller local epidemics, each of which has unique characteristics. Prevention funding, including new funds to respond to the needs of communities of color, must be coordinated through these local planning and coordinating mechanisms so that comprehensive, evidence-based programs can be designed, implemented, and evaluated.

Our current system of funding AIDS prevention must be implemented through a coordinated partnership of affected persons, community leaders, and local and state health officials. This is the worthy goal of community planning, but it will not be realized without support and leadership.

9. BUILD LONG-TERM COMMUNITY CAPACITY FOR PREVENTION

Community capacity is essential for implementing this plan at the local level. Unfortunately, many of the communities hardest hit by this epidemic lack the infrastructure necessary for a sustained response. While several initiatives are underway to build the local capacity needed—including the Congressional Black Caucus minority AIDS initiative you announced in October of 1998—more needs to be done. Our technical assistance efforts must move from distant providers to long-term, sustained mentorships by those who know how to build local agencies. In addition, help is needed in building bridges between these community organizations and prevention researchers to improve the connection between our prevention interventions and research projects.

10. REQUEST MORE PREVENTION FUNDING

While the need for sustained HIV prevention efforts has been growing, the Federal AIDS prevention budget has remained essentially flat for several years. The best strategic plan in the world will do little good if there are not the resources in place to implement it. We must use the current community AIDS prevention planning process to articulate unmet need so that we have a better understanding of the level of resources we must seek. Here are some visions of how additional resources could address some of the previous nine points, and would accelerate our goal of a 50 percent reduction in new HIV infections:

—The community planning process has been useful both in prioritizing interventions and also in identifying unmet needs in communities. A systematic effort should be made to collect information about what works, what does not work, and what more is needed from community planning groups. A special fund could be established to prioritize these needs and provide additional funding as needed to fund unmet needs.

—HIV counseling and testing has been proven effective, especially in reducing risky behavior among HIV infected individuals and transmission within serodiscordant couples. Enhancements could include implementing new testing strategies such as rapid testing and oral testing, improving referral and linkage to care, expanding outreach and use of mobile units, and increased emphasis on identifying acute and primary HIV infections. Passive, clinic-based counseling and testing is not nearly as effective as active outreach to those most likely to be infected.

—Researchers have documented the relationship between bacterial STDs and heightened transmissibility of HIV. However, the historic split between HIV and STD prevention (and a conflict in basic philosophies—HIV strongly behavior change and STD steadfastly traditional biomedical) serves only to allow for undue risk levels in communities. Integrating these distinct, yet inter-related, prevention programs is worth the effort it takes: the links between HIV and STDs should be beneficial to their eradication, not increased transmission.

—Drug treatment on demand has been proven effective in reducing the transmission of HIV and other blood-pathogens. Providing drug treatment on demand in every locale would go a long way to reducing the burden of drug abuse and the spread of HIV.
—Campaigns are needed to reinforce current prevention messages and to promote condom use, to increase awareness of the importance of knowing one's HIV status, to encourage parents to talk to their children about sexual safety, and to reduce stigma and discrimination against people with HIV.
—Creative initiatives need to be undertaken to link prevention and care, as every new HIV infection can only result from unsafe encounters between infected and uninfected individuals. Making prevention the standard of care in clinical practice, providing funds for demonstration programs, and providing reimbursement for prevention visits could encourage HIV prevention in the context of clinical care.
—Clearly the need to address the risk reduction activities of people living with HIV is a national mandate and helping develop more innovative prevention intervention models for this group is essential.
—Funds are needed to expand efforts through national and regional minority organizations, to expand capacity building in communities, to conduct specialized needs assessments, and to expand technical assistance in transfer of prevention science. This goal is best accomplished through coordination with evidence-based approaches.

Mr. President, it is one thing to live through an epidemic as devastating as HIV and quite another to write its history. Will future generations looking back on this epidemic chronicle our achievements or criticize our failures? Undoubtedly, there will be some of both. The US and other industrialized countries have made HIV a top scientific priority. The U.S. budget research budget for HIV/AIDS will climb to over $2 billion in this fiscal year. The activities of the world's scientists have led the way to better diagnostics, therapeutics, and prevention strategies.

Your Administration can be proud of its record on HIV/AIDS care and research. Your leadership has sustained the successes of the Ryan White CARE Act, the research program at the NIH, and the global efforts of USAID. Work with us to add HIV prevention to that list. A strategic, sustained prevention effort can not only severely curtail the epidemic in this country, but may also serve as the proving ground for prevention efforts world-wide. Indeed, prevention may be the developing world's only hope. Help us prove that prevention works here and now.

Sincerely,

THOMAS J. COATES, PH.D.,
Professor of Medicine and Epidemiology, Director,
UCSF AIDS Research Institute and Center for AIDS Prevention Studies.

Dr. COATES. It recommends a 10-point plan for reducing the number of infections in the United States from 40,000 a year to 20,000 a year. And I won't go through all of the 10 points because I don't have time. But we do recommend developing a results-oriented administration-wide strategic plan for prevention. We do ask for coordinated multi-tier efforts. We do ask that research be useful to planners and providers.

Another part of the success story of the NIH, the research success story, is in HIV prevention. We have invested some $200, $250, $300 million a year in prevention. We have proven effective techniques.

And we want you to push the NIH and the CDC further to bring research together with community planners and service providers in new and novel ways by establishing centers of excellence, by sharing knowledge of proven prevention methods and by increasing the impact of minority investigators.

We also request more prevention funding, our last point, and talk about a number of areas in which increased investment would be worthwhile. I won't go through those in detail but they are in the record. And there are plenty of places for investment.

Dorothy Mann mentioned HIV-infected people and that there's only one way that infection can spread, from the infected to the

uninfected. We do need services for HIV-infected people. But we also need leadership from Congress to make it safe for HIV-infected people to identify who they are and not to criminalize the exposure of someone else to this disease. That will only drive people underground. It's very easy to get stigmatizing and moralizing and judgmental about the ways in which people might expose other people to HIV. But believe me it happens for a variety of reasons. And I say this as a person living with HIV myself and someone benefiting from this science. My life is long and of good quality because of the medications I am taking. But the HIV-positive community needs to be challenged to take responsibility. But we also need to make it safe for people to do that.

The last point I would like to make has to do with the global issue. And I know that this is not necessarily the purview of your Committee, but I do want to make the point.

Across the e-mail this week came this thing that said "Health warning." Think about one passenger jet—and we had the Alaska jet crash—crashing every hour of every day, all year long, killing everyone onboard. Well, that is how many people died of AIDS in Africa in 1999. One jet, every hour of every day.

Now we get sort of numbed by these numbers. We have gotten kind of used to these numbers. OK, HIV is there; it is in subSaharan Africa, and it is getting worse. And it almost becomes staggering, and we don't know what to do about it.

Well, the truth is that the reason that HIV is spreading so rapidly is not because of lack of know-how. We know how to stop the spread of HIV. The science from the NIH has given us plenty evidence-based prevention strategies.

The problem is resources. Senator Boxer's bill, Ms. Lee's bill is a start. But if we were willing to invest $2.5 billion a year in the developing world—and right now the investment, the U.S. investment, is $145 million. That's all we send overseas. If we were willing to increase that to $2.5 billion, we could decrease the number of new infections in the developing world by half.

When the future writes about this era of the epidemic they will commend us for many things. They will commend us for the contribution we have made to science, enormous, unprecedented in the world. They will say that we did a great job of taking care of people with HIV. But they will really take us to task for our failure to cut the number of infections in half in the United States and to really invest heavily in the developing world because this carnage doesn't need to happen.

Thank you.

Senator SPECTER. Thank you very much, Dr. Coates. We are going to come back to that issue and some of the others in the question-and-answer period.

STATEMENT OF DORETHA FLOURNOY, EXECUTIVE DIRECTOR, AIDS PROJECT OF THE EAST BAY

Senator SPECTER. We now turn to Ms. Doretha Flournoy, Executive Director for the AIDS Project for the East Bay, Oakland; Board of Directors of the National Minority AIDS Council and Co-chair of the African American State of Emergency Task Force. She also Co-chairs the Bay Area Black AIDS Collaboration. She holds an ABD

in Clinical Psychology from Penn State, M.S. in Clinical Psychology from San Francisco State University and a B.A. in Psychology and Public Health from the University of California Riverside.

Thank you for joining us, Ms. Flournoy. We give you the floor.

Ms. FLOURNOY. Thank you. I must say that I am very honored to be here. This is the first opportunity that I have had to speak in this type of forum and to be in the presence of such, what I call, large people, people who have a great deal of influence over what happens both nationally but also in the individual lives of the people that I serve.

And I must also sort of admit that being here is sort of an intimidating process, you know, watching the professionals talk about what they know to be true about AIDS and people who have done research and know the ins and outs of treatment issues for people living with HIV. And even with all that I have done I sit here somewhat in awe, you know, intimidated by the process, and the people, and the systems that are created to meet the needs of the very people that I serve.

And I only imagine what it is like for the young man sitting on the corner who doesn't have a job, and didn't finish school, and doesn't know that he can go to his health provider and get the services that he needs, or the young mom who is overwhelmed with, you know, three or four kids, where the kids are in, you know, dangerous settings at school. And she's living in a drug-infested community and when she goes to the hospital doesn't feel as if her doctor is hearing her, and that the medical providers there don't have time for her. I can only imagine what they must feel in trying to access this kind of a system to get their needs met, to get their voices heard.

And so as I was sitting in the audience I just kind of thought about it. And I said, "Wow, who speaks for them at this table? You know, where is their voice?" And so, you know, whereas I have had a great deal of experiences I am going to make that effort to do that for them. And I must say, too, that I have considered it a privilege to serve as the executive director for AIDS Project of the East Bay.

But I didn't start there. You know, I was thinking this morning about where I started in the process of helping people make changes in their lives. And I remember sitting in the park in Watts watching the drug dealers and people addicted to drugs and watching, you know, issues of domestic violence kind of splashing through the community. And also, you know, watching in my own family, you know, people dealing with poverty issues and struggling through school. And, you know, folks have died, you know, just without AIDS, without dealing with AIDS at all.

And I made a commitment then, you know, at the age of 11, 12 that I would engage the process, that I would do what it took to help people make individual change. And as I have gone through school, and as I have had experiences working as a clinician in the Watts Health Foundation, in community mental health settings, and doing outreach in Marin City, and the like, under other circumstances beyond AIDS I realize how difficult it was to help people make individual change.

We keep talking about systematic changes here. We talk about funding streams. But really to get a person to make an individual change in their behavior is a daunting thing. These folks are overwhelmed with issues, the issues that I have just raised, you know, substance abuse issues, domestic violence, feeling alienated from systems that are supposed to help them, not having access and opportunities that could change their life circumstances and walking away from a table without hope, without hope for their lives, without hope for their future, without hope for their children, and just surviving from day-to-day.

And here we come, here comes AIDS. Now one more thing to put on the plate of these people who are already overwhelmed, already suffering, already going through. And we want them to change the very behaviors that give their life meaning in the moment. And that is a difficult task. It's a difficult task. I think that from a prevention perspective that—and we provide prevention to over 20,000 people annually.

But when we have to sit down with an individual and start talking about the specific changes that they need to make in their lives these other factors weigh heavily in that process. It weighs heavily in their ability to consistently maintain the use of a condom. It weighs heavily in their ability to talk to their partner who may have the very resources that they need to survive about their own risk and their ability to protect themselves. All of those things impact our clients, and we have to work on those things.

We have used the strategies that have come from San Francisco as best as we can. The population I serve is over 76 percent African Americans. And yet in Alameda County we still have the highest rate. African Americans still bear the burden of the disease.

So for us change goes beyond just a scientific knowledge of what it takes to prevent AIDS. We are talking about social changes. We are talking about economic changes. We are talking about empowering people to change their own outcomes and then to feel good about their lives enough to protect themselves.

I have actually had people say to me, "Why should I get tested? What is it going to change in my life? And if I die early it might be a good thing."

So, again, I thank you for allowing me to sit at this table. But just know that what we do is difficult. And as a provider, as a grassroots on-the-ground provider, that the support that we get from you all is critical. Whenever you change modes, we change. We have to change strategies, we have to change staff, we have change.

PREPARED STATEMENT

So if we had a consistent commitment to this fight that goes beyond just the scientific knowledge, that goes into the lives of people that are being impacted, that will create the greatest amount of change.

Thank you.

Senator SPECTER. Thank you very much, Ms. Flournoy. That was very eloquent. We'll come back to some of those issues when we have the question and answer.

[The statement follows:]

PREPARED STATEMENT OF DORETHA WILLIAMS-FLOURNOY

AIDS Project East Bay (APEB), located in the heart of Oakland, California, is the largest AIDS-related agency in the East Bay region, and the only organization in that region devoted exclusively to providing services and prevention programs that target HIV and AIDS. APEB provides services to approximately 1,000 clients who have HIV/AIDS, and its prevention messages reach approximately 20,000 persons annually, persons who are at risk of becoming infected with HIV or with transmitting the virus. Among the services APEB provides are psychosocial case management, housing case management and direct housing assistance, entitlements and public benefits advocacy, peer advocacy, treatment advocacy, and the provision of direct emergency services. Of APEB clients, 85 percent are people of color. Seventy-five percent are African American. One-half are heterosexual. Over half are active or recovering substance users. Over one-third are homeless or marginally housed, and 30 percent are women.

APEB operates extensive prevention programs that target African American men who have sex with men (MSM's), transgendered persons, gay-identified youth, and non-gay-identified youth. The prevention programs reach over 20,000 persons in many areas, but particularly in the East Bay. Alameda County, located in the East Bay, and the nation as a whole, have experienced HIV/AIDS moving aggressively into communities of color. Nationally, African Americans are about 13 percent of the population, but comprise over 40 percent of all new AIDS cases. When all communities of color are considered, persons of color account for nearly, and perhaps more than, the majority of all new AIDS cases. Recent data from 1998 indicates that among men who have sex with men, people of color have surpassed non-whites to become the majority of all newly infected persons. In all measures of health outcomes, people of color underperform compared to whites. People of color get tested for HIV later in the progression of their disease than whites, are more likely therefore to progress to an AIDS diagnosis, and progress to an AIDS diagnosis more rapidly than do whites, and are more likely to die earlier than whites, and are less likely to reap the benefits of new drug therapies. In 1998, APEB and other Alameda County community leaders, with the help of Congresswoman Barbara Lee, advocated for the declaration by the Alameda County Board of Supervisors of a state of emergency in the county's African American population due to the disparate and alarming impact of HIV and AIDS in the region.

APEB, during the course of providing extensive prevention and outreach to over 20,000 high-risk individuals has learned a great deal about the barriers to effective prevention services. The circumstances in which individuals live their lives will impact their behaviors, and thereby their chances of becoming infected with HIV, or of infecting others with HIV. The social ills that the at-risk community suffers from influence their behavior. The high-risk community APEB reaches with its prevention programs suffer from poverty, low self-esteem, guilt over the way they live their lives, or the way society views their lives, fear, fear of authorities, including the medical establishment, fear of the stigmas attached to one's HIV status, or their sexual orientation; and a profound lack of access to mainstream opportunities, such as education, jobs, health care. People feel marginalized. All these variables impact one's behavior. If a transgendered persons, for instance, cannot find work based on his or her lack of experience, education, or because of societal fear or discrimination, that person is more likely to need to work in the sex industry, thus exposing himself or herself to a greater risk of infection. If individuals are unable to make life changes, behavioral changes will not be consistent.

We need to maintain and expand our country's commitment to prevention. The hurdles are severe but through persistence over a sustained period we can make an impact in changing individual's behavior and in changing the circumstances of their lives that influence their behavior. In this way, supportive social services are in fact an integral and necessary component of an effective prevention strategy. Finally, even if we make inroads in reducing new HIV cases, there will be many survivors with HIV capable of transmitting the virus. Therefore, we cannot afford to reduce our prevention efforts no matter what successes we may have on other fronts.

STATEMENT OF LONNIE PAYNE, PRESIDENT, BOARD OF DIRECTORS, SAN FRANCISCO AIDS FOUNDATION

Senator SPECTER. Our final witness of this panel is Mr. Lonnie Payne, elected as Chair of the Board of Directors of the San Francisco AIDS Foundation just last month, a member of the Foundation's Board of Directors for the past 5 years. Like his fellow board

members he has been personally affected by the AIDS epidemic, living with HIV for more than 14 years.

He earned his Bachelor's Degree in Voice Performance at the University of South Carolina and a Master's Degree in Music with emphasis on opera from Northwestern University.

Mr. Payne is a repeat witness. He was here last July.

Mr. PAYNE. That's right.

Senator SPECTER. Thank you for joining us, Mr. Payne. And we look forward to your testimony again.

Mr. PAYNE. Thank you.

Good afternoon, Chairman Specter. It's good to see you again, and Congresswoman Pelosi.

My name is Lonnie Payne, and I am Board Chair for the San Francisco AIDS Foundation. I am also a person living with HIV. Contrary to something we heard earlier today my life has been elongated because of the treatments. If it were not for some of the treatments I would not be alive today. So it is important that we understand people truly are living longer because of the roads we are making with the new treatments and the medications.

I really want to thank you for holding this field hearing today.

Two years ago a poster began appearing around San Francisco that stopped many people in their tracks. Accompanying a drawing of a young black man were the words "Racism, homophobia, which do you prefer?" The message was simple, direct, and powerful.

As an African American gay man living with HIV, I believe the poster spoke with startling precision to the reality that many gay and bisexual men of color encounter every day of our lives.

This was initiated by the San Francisco AIDS Foundation's Black Brothers' Esteem Program. The racism and homophobia campaign was based on research that was conducted by the Foundation and also UCSF's Center for AIDS Prevention. It indicated that racism and homophobia gay and bisexual African American men experience is a significant factor in HIV infection.

Facing hostility and rejection within the black community as well as in society as a whole many of the African American men who participated in the research study reflected lives deeply steeped in feelings of isolation and lack of self-worth. Those feelings, in turn, led to feelings to self-destructive behavior patterns, including behavior that increased the risk of HIV infection.

Given this background it was not surprising that the National Centers for Disease Control and Prevention recently announced that in 1998 the number of AIDS cases among gay and bisexual African American and Latino men had, for the first time, exceeded that among gay and bisexual white men.

It was also not surprising that the CDC specifically cited homophobia as a significant factor in the risk for HIV infection among men of color.

As a whole, black gay men have been invisible in the American society. We have been scorned within the black community, which often denies our existence as gay men or views us with open hostility. In the general society, as well as in the wider gay community where racism is as prevalent as it is in society as a whole, we often encounter rejection and marginalization due to the color of our skin.

The effects have been devastating, contributing to rates of HIV infection among men of color that far exceed those among other groups.

Some may believe that self-esteem and identity are merely tangential factors that play only a minor role in the spread of HIV. This view, however, is difficult to sustain in the face of mounting data about what affects individual sexual decisionmaking.

It is now absurd to ignore that feelings of self-loathing, isolation and worthlessness are core factors in HIV infection. If we as a society want to have an impact on the number of new HIV infections, we cannot afford to ignore the core issues.

There is a deadly synergy of homophobia, AIDS phobia and racism at work, and it is devastating the black community. Some believe the stigma attached to homosexuality is greater within the African American community than it is among whites. Others say the stigma itself is not greater, but rather that black men must rely more on their community as a source of sanctuary, and so rejection by the community has a greater and more destructive impact.

In either case, the result is the same: a powerful fear that leads men to feel isolated and to remain hidden, presenting a major impediment to HIV education and outreach efforts.

PREPARED STATEMENT

In too many instances the African American community has responded with silence and denial to this plague that is ravaging its own. The evidence is now clear. No one can claim ignorance. Prominent public figures, from spiritual leaders to sports figures, performing artists and politicians must speak out. The media must do its part to raise awareness. And private and government agencies must not shirk their responsibilities. If we are to have the accelerated targeted and comprehensive response that is crucially needed, all these groups must play their part. Let us hope that these new grim CDC statistics are a catalyst for the urgent action that is so desperately needed.

Thank you.

Senator SPECTER. Well, thank you very much again, Mr. Payne.

[The statement follows:]

PREPARED STATEMENT OF LONNIE PAYNE

RACISM. HOMOPHOBIA. WHICH DO YOU PREFER?

Two years ago, a poster began appearing around San Francisco that stopped many people in their tracks. Accompanying a drawing of a young black man were the words "Racism. Homophobia. Which do you prefer?" The message was simple, direct and powerful. As an African American gay man living with HIV, I believe the poster spoke with startling precision to the reality that many gay and bisexual men of color encounter every day of their lives.

Initiated by the San Francisco AIDS Foundation's Black Brothers Esteem Program, the Racism/Homophobia campaign was based on research conducted by the Foundation and UCSF's Center for AIDS Prevention, which indicated that the racism and homophobia gay and bisexual African American men experience is a significant factor in HIV infection. Facing hostility and rejection within the black community, as well as in society as a whole, many of the African American men who participated in the research study reflected lives deeply steeped in feelings of isolation and lack of self-worth. Those feelings in turn led to self-destructive behavior patterns, including behavior that increased the risk for HIV infection.

Given this background, it was not surprising that the National Centers for Disease Control and Prevention recently announced that in 1998 the number of AIDS

cases among gay and bisexual African American and Latino men had for the first time exceeded that among gay and bisexual white men. It was also not surprising that the CDC specifically cited homophobia as a significant factor in the risk for HIV infection among men of color.

As a whole, black gay men have been invisible in American society. We have been scorned within the black community, which often denies our existence as gay men or views us with open hostility. In the general society as well as in the wider gay community, where racism is as prevalent as it is in society as a whole, we often encounter rejection and marginalization due to the color of our skin. The effects have been devastating, contributing to rates of HIV infection among men of color that far exceed those among other groups.

Some may believe that self-esteem and identity are merely tangential factors that play only a minor role in the spread of HIV. This view, however, is difficult to sustain in the face of mounting data about what affects individuals' sexual decision making. It is now absurd to ignore that feelings of self-loathing, isolation and worthlessness are core factors in HIV infection. If we as a society want to have an impact on the number of new HIV infections, we cannot afford to ignore these core issues.

There is a deadly synergy of homophobia, AIDSphobia and racism at work and it is devastating the black community. Some believe the stigma attached to homosexuality is greater within the African American community than it is among whites. Others say the stigma itself is not greater, but rather that black men must rely more on their community as a source of sanctuary, and so rejection by the community has a greater and more destructive impact. In either case, the result is the same—a powerful fear that leads men to feel isolated and to remain hidden, presenting a major impediment to HIV education and outreach efforts.

In too many instances the African American community has responded with silence and denial to this plague that is ravaging its own. The evidence is now clear and unequivocal. No one can claim ignorance. The African American community must end its denial and inaction. Prominent public figures, from spiritual leaders to sports figures, performing artists and politicians must speak out. The media must do its part to raise awareness. And private and government agencies must not shirk their responsibilities. If we are to have the accelerated, targeted and comprehensive response that is crucially needed, all these groups must play their part. Let us hope these new grim CDC statistics are a catalyst for the urgent action that is so desperately needed.

Senator SPECTER. Ms. Mann, let me begin with you on a 5-minute round, and ask you a question in two parts for one response.

Ms. MANN. I'll try.

Senator SPECTER. You make a comment that only four babies born in Philadelphia, out of 10,000, are HIV-positive.

And I'd be interested to know if you think our hospital visit some 12, 13 years ago had anything to do with that?

I'll ask you the second question after you answer that.

Ms. MANN. Yes.

Senator SPECTER. Is that the correct statistic, 4 out of 10,000?

Ms. MANN. Yes, I think it is. I mean, I didn't check with the Health Department on the exact number of births.

Senator SPECTER. That's a remarkable statistic.

Ms. MANN. I do know that the number four is totally accurate. That I did get from the Health Department. And in my head it's 10,000 births. It's approximately. If it's off it's off by—we had 9,000 births and not 10,000. But it's in the magnitude, yes. And I think it's direct relationship.

There are two reasons why we have gained such enormous success in this area. One is very simple. It's the investment in research. The reduction in perinatal transmission is the most success we have had in prevention, in my judgment. And we don't talk about it very much. And we don't crow about it enough. The fact is the investment in research and NIH started this process. The results indicated that if you took and administered medication to a

pregnant woman, and during labor and delivery, and to the infant, that you could use this spread.

Then what happened, the rest of the Federal Government, actually some of those jewels, in addition to NIH, responded appropriately, HRSA and CDC. CDC by issuing guidelines, HRSA by implementing this at the program level. And, in fact, we have had an enormous success. And it's sort of the model that needs to be used in so many ways, of taking the results of research and transferring it to CARE and to communities and to action. That technology transfer from what can work is really just not done well enough. So I think this is an enormous success.

Yes, I think you're introduction to this—and I also have to say one thing, just as a personal thing I have say, because everybody should know this—that when there was an opportunity for you to receive some press attention for that visit you actually said, "No," that that's not why you were there, that you were just there doing your job. It was an extraordinary thing for you to have done. And I know you saw those children and you spoke to those families. And the programs that we now have in the Nation are a direct result of that, but not if you hadn't been there.

Senator SPECTER. Well, that's sufficient attention today, Dorothy. Thank you.

Ms. MANN. But it's true.

Senator SPECTER. Let me pick up on something you said and integrate it into a question to Dr. Coates because of the limitation of time.

You are correct when you articulate the proposition that if we had a war with 40,000 deaths it would be insufficient. And Dr. Coates talks about $2.5 billion for Africa. And that raises the lot of collateral issues which we don't have time to go into. But we have a lot of criticism of our subcommittee on the allocation of NIH to AIDS, HIV, because of the number of people afflicted. And as our subcommittee stays clear of making the allocations strictly so that we don't politicize such a very important program.

One of our prominent members of the Appropriations Committee wanted to put $150 million into prostate cancer and got turned down. And it's been in the public domain as the chairman of the committee, chairman of the full committee.

So, Dr. Coates, arm me with the best argument can, because I'll hear it again very soon about why HIV is so much more proportionately than Parkinson's or Alzheimer's or even breast cancer?

Dr. COATES. Every disease is a serious disease to the individual who's afflicted by it and to that person's family. I think we never get very far when we start pitting one disease against another and saying, "My disease is worse than your disease," and "This disease should get more than that disease."

I think what we need to do, particularly in case of the NIH, is think about the potential of scientific opportunity. HIV came along at a time when the retro virus had been discovered. And because of the increased investments we were very quickly, by 1985, able to have an antibody test against it, very quickly to develop medications against the reverse transcriptase enzyme, very quickly to develop drugs against the protease enzyme and now against the fusion enzyme, and the integrase enzyme. So we are very quickly

moving because of the scientific investment. So it really is on the basis of scientific opportunity.

And if we crack the vaccine puzzle, and we will for HIV, we will learn a lot for a lot of diseases because we will learn how to make immunity for the first time for a disease against which we don't have natural immunity. The scientific opportunity is so great. And I think that's the basis upon which investments need to be made.

Senator SPECTER. Thank you, Dr. Coates.

I'm going to yield with the red light on to Congresswoman Pelosi with the additional comment that we justify in part the allocations which NIH has made because we have added so much money to everything else, to Parkinson's, breast cancer, prostate cancer and Alzheimer's. You talk about the metaphor of the rising tide and the boats. Well, they're over the bathtub, really, at this point, from what funding we have added.

Congresswoman Pelosi.

Ms. PELOSI. Thank you, Mr. Chairman, very much.

I was so impressed by the presentations made here. And you and I have both sat through many AIDS hearings.

But, Ms. Mann, thank you very much for your very valuable contribution. And Dr. Coates, always. Ms. Flournoy, how remarkable you are. And Lonnie, of course, he's a tremendous resource to us, Lonnie Payne. But very important testimony.

I want to just rat-a-tat-tat a few things. First of all, in terms of the global issue of AIDS, we have been talking about this for 10 years, at least, about the global aspects of it. I'm the ranking Democrat on the Foreign Operations Subcommittee which gives that meager $147 million. And we have to work very hard to get it.

In fact, I have to say to my chairman, year in and year out, "If I don't get that money, I don't vote for the bill." Sometimes I don't vote for it anyway. But unless I get the money, I won't even consider it. And that's a pittance. And we have been saying all these years, "Put this on the agenda of the G7. If you're talking about the economies of developing countries that you can't talk about them unless you talk about AIDS."

So years later, so many people lost to us, now all of a sudden it's been discovered by the United Nations. What have they been doing all these years? All the a sudden it's on the agenda, and everybody is celebrating. I said, well, welcome to the world of the alive. This is no secret. It's been no secret. So I think that we have been as a country and as a society enormously delinquent not only at home but on the international AIDS issue which has been so obvious.

And in our community the mobilization against AIDS, which has been mobilizing on the AIDS issue domestically for years, years ago changed their mobilization to international AIDS issues.

So this is a tragedy and it is a missed opportunity of lives lost and the ability to hold this thing in check a long time ago. OK, so we have that.

Now we have—and you talked about $2.5 billion and our measly $147—now they're asking us to do $1.5, $1.6 billion for Colombia to fight to win the war on drugs. And we know what the relationship to intravenous drug use to the new demographics of AIDS is. And, again, it's my committee, I'm going to Colombia this weekend to see what this is about.

And I'm saying, "If this is about the war on drugs we want $1.5 million for treatment on demand for prevention and, in our country, if we are going to stop this drug epidemic, which is directly related to what we are talking about here because the new face of AIDS, of course not that new, but is getting worse among people of color and IV drug users."

That's why I was very annoyed. We are used to people disrupting our meeting. It's a matter of course here. But for five white people to come in here and say, "The AIDS epidemic is over," I'm sorry. I'm sorry. That is completely—you know, I lose patience with that.

So I'm glad that you enlarged the issue, Ms. Flournoy, and all of you about the context with what it just is. When we talk globally we are not only talking geographically globally, but globally in terms of this issue in the context in which it takes place.

And I was pleased that—Senator Specter and I were the only two—well, I was pleased that we were the only two—but I was pleased that we were there when the President rolled out the minority AIDS initiative last year. Everyone there was from the Congressional Black Caucus. But we were recognized for our work in helping to fund that. It's not enough money but it will hopefully make a difference. And that's why I, when I went to Congress, this is the Subcommittee that I had to be on because of our community.

Any of you can comment on that. But, Dr. Coates, I wanted to ask you specifically, how much money to you think is needed reduce the number of new infections from 40,000 to 20,000?

Dr. COATES. Well, I'd be happy to follow with a more detailed accounting. But we think an additional $380 million a year in the HIV prevention account could do the job, going for things such as treatment on demand, Federal funding of needle exchanges, greater condom availability, buying air time to advertise condoms and such, linking investigators, preventive research centers such as our own with local communities. About $380 million a year.

Ms. PELOSI. Would save 20,000?

Dr. COATES. Would save 20,000 lives.

Ms. PELOSI. When you say, "treatment on demand," are you talking about for IV drug use?

Dr. COATES. IV, drug treatment on demand, because every day——

Ms. PELOSI. So you're establishing that relationship for us?

Dr. COATES. Exactly. Because every day a drug user is in treatment is one less day that that person is infecting someone else, if that person is infecting, or getting expose.

Ms. PELOSI. I appreciate that, thank you.

Dr. COATES. But we'll send more detail.

Ms. PELOSI. And any other documentation that you would have would be good.

I invite our witnesses to make any comments—oh, I guess my time is up.

Senator SPECTER. Yours is, but theirs isn't.

Ms. PELOSI. No more questions from me, but, please.

Ms. MANN. I would like to make one comment. I've been in these vineyards of at least preventing unintended pregnancy for forever, it seems. And one of the things I remember several years ago was in the beginning of this notion about preventing teen pregnancy,

that somehow if I had in my program any hope of preventing teen pregnancy I had to solve every societal problem you could name.

Well, guess what, we are really succeeding in reducing teen pregnancy because we know what works. We know what to do. We haven't solved society's problems. It worries me sometimes when we think we can't get anywhere unless we do everything and fix everything. That's not the way these things work. We do know a lot about what to do. And we can do better, and we are doing better.

So I really just want to put the notion that 40,000 people are newly infected every year in this country—I was, in my cab ride very late yesterday, or early this morning, from the airport to here, the cab driver asked me what I was doing here. And I told him.

And I said, "One of the things that the real problem is that we get 40,000 new infections a year."

He said, "We do?"

That the general public in this country has no idea what we are, in fact, accepting among our people. They have no idea. I can't figure out why we are not telling them. And he was astounded that that would be the case.

And I really think that we have gotten complacent about this disease in a lot of ways. And I really hope that not only through much greater financial investment in prevention but also somehow a greater public awareness of the numbers of people that keep getting this disease will raise the public's consciousness as well as—obviously, you already are there. We have a lot more people to educate.

Senator SPECTER. I was not serious when I said that Congresswoman Pelosi's time was up. She can have as much time as she wants.

We are going to take a few minutes more, if we may, for another round because we haven't heard from two of our witnesses.

I was interested in what Congresswoman Pelosi had to say about voting for the bill because, as she said, she wouldn't have voted for the bill anyway.

Ms. PELOSI. No, I might not have.

Senator SPECTER. And we agree on many, many things but we have a minor disagreement on whom we wish to control the House of Representatives next year.

But in the event——

Ms. PELOSI. It's not minor, Senator.

Senator SPECTER. In the event that Congresswoman Pelosi's dream comes true I, for one, will be very interested to see how far her Chairmanship, Chairwomanship, Chairpersonship of the Foreign Operations Subcommittee will move from $145 million to $2.5 billion.

Dr. Coates, and your constituent, and somebody may be her as well as Arlen Specter, so we will see.

Ms. PELOSI. With all the other money added in, we are up to $190—now. So we only have to multiply it by 1,200 percent.

Senator SPECTER. One more comment about just a touch of partisanship. That's a fascinating letter you sent to the President, Dr. Coates, your 10-point program. It was the only thing that he left out of the State of the Union speech.

Dr. COATES. I know. I was listening.

Ms. PELOSI. Actually it was in, and then it was out. In the written initial comments there was domestic AIDS and international AIDS. And then the surviving product, if I may.

Senator SPECTER. Congresswoman Pelosi knows a great deal more about the exogenesis of the State of the Union speech than I do.

Ms. PELOSI. Well, we phrased what was in there in our statement written in advance of hearing the speech. And then it was in there.

Senator SPECTER. I was one of the few Members who stayed for the entire speech.

Ms. MANN. And stood up occasionally.

Senator SPECTER. Ms. Flournoy, let me come back to you for a question.

You really struck a chord when you talked about victims and needs—America's voice is heard. And you so accurately talked about the social economic changes that have to be brought to bear.

I was a city official for many years, and I remember 1967 when a book was written, Cities in a Race with Time. And the thrust of the book was that the cities were out of time. And like Congresswoman Pelosi I've still got some time left and still watching the cities, still watching Philadelphia and San Francisco. We are not too far behind San Francisco on the HIV problem. New York's first, L.A.'s second, you're third and we are not too far behind in Philadelphia.

But on the issue, the broader issue, of trying to solve these problems on socioeconomic changes, you're a little younger. But do you see any improvement? Have we progressed any? You can't go back to 1967. But do you see improvement up to now and do you see any realistic hope for improvement, regardless of who controls the U.S. House of Representatives?

Ms. FLOURNOY. I think that generally there are populations of people who have had more access. I personally am a product of affirmative action and have benefited a great deal from that experience and have been exposed to life circumstances that I would have never had. And when I look at my family, in particular, you know, they have not had that experience even as a result of, you know, just being in relation to me.

So there are pockets of people who have had a great deal of success. But I think that you also have a great deal of people who still feel alienated from the process. I think if you listen to rap music, that's an indicator right there of how alienated our youth feel, how out of the mainstream they feel, how ineffective they feel and the types of strategies that they are willing to engage in order to make change in their own lives, or to effect change in the lives of others and to get the attention of, you know, gatekeepers.

And so I believe that there have been successes. I believe that the fact that an agency like AIDS Project does exist at all, you know, is a good thing. You know, there are some communities that don't even have that type of resource available to them. But yet still it goes back to the individual. If the individual is not experiencing the change, if the individual doesn't feel as if they can con-

trol their own outcomes, then that individual is not likely to engage consistently in behavior change.

And the sad part about the AIDS epidemic is that even though we—and I guess you've heard earlier from reports, from Helene Gayle and others, that we are likely to see this disease resurge if we don't do something to deal with the psychosocial issues that are addressing an individual's willingness or ability to engage in the behavior change. So educating them about HIV is important. And we have done that in our community. We are talking to people. When we talk to people. We walk up to people on the street, "What do you do to protect yourself from HIV?"

"I can use a condom."

"Do you use a condom consistently?"

"Well, no."

"Are you willing to, you know, say no to the boyfriend that you have over there who's pressuring you to have sex without a condom?"

"Well, I don't know about that."

You know, there's some ambivalence around there. I think that there's some social issues that need to be addressed in this disease and especially because it's moving into people of color communities that have other issues on the table that are competing with AIDS.

As an organization the CDC initiative was very helpful for us, extremely helpful for us. I mean, it allowed us to now sit back and stop operating from a crisis perspective and start planning for services. And that's actually where these comments are coming from, because I can see on the horizon the limitation in what we are able to do if we maintain the kinds of services and programs that we have now.

We need to link with social organizations, mental health services, substance abuse treatment facilities, educational facilities, job training facilities and create an environment where people who are infected with HIV will feel capable of managing their lives, now that they are going to live. That's an issue for us. And I think it will impact our ability to keep the progression to—decrease the progression of this disease in people of color communities.

Senator SPECTER. A final question, even though my red light is on, Mr. Payne. I'm delighted that you're here again. I'm delighted to hear that you're doing well. You look good.

Mr. PAYNE. Thank you.

Senator SPECTER. With the medicines that you have available, the pharmaceutical advances.

On this CDC study, which I commented on earlier, where the availability of the pharmaceutical assistance has led so many HIV people to be less concerned, less careful, I'd be interested in your views as to how we cope with that problem?

Mr. PAYNE. Well, I think it goes back to this breaking the silence. I think we have to take a personal responsibility to be able to talk about our HIV status, in some cases, or our sexual practices. When we talk about the stigma in the African American community—I'm sure the stigma of homosexuality also exists in other communities—but it seems to be stronger in the African American community.

And so if someone is fearful of telling about their sexual preference, then they are fearful to talk about the practices that they do. So they are fearful to talk about, "I might have put myself in a situation where I might have been with someone who was infected with HIV."

So the silence is always there. Now we have to get better. We have to take a more personal ownership in trying to break that silence.

One of the things that the San Francisco AIDS Foundation is doing, we have a campaign that's called, "The Assumptions Campaign." And everyone knows all of the ins and outs about safe sex, about how to use condoms, and the like. But our studies and our program is telling us that people are still making some wrong assumptions.

They are assuming either someone is not positive or someone who is negative without having a dialogue. And I think that particular piece transcends not only the gay community but it transcends all communities, I think. We have to be able to talk about what we are doing sexually to stop the spread of HIV.

Senator SPECTER. Congresswoman Pelosi, another round.

Ms. PELOSI. Well, Mr. Chairman, of course you'll have the last word. So I'll be brief now because we have to go to San Francisco General Hospital shortly.

But having this wealth of talent here I would say that it reminds me how blessed we have been in this tragic epidemic, of how blessed we have been with the champions, the people who have taken this issue so seriously, who have dedicated their careers, if they are scientists, and doctors, and people in the community at the grassroots level have really risen to the sad occasion of bringing us community-based solutions and being very generous in terms of speaking out personally about what it means to them. It's not only in the African American community but also in our Asian American and Hispanics or Latino community in our city.

It has some of the stigma in some of the denial that Mr. Payne described earlier in the African American community. But we have been very blessed in our community and very generous, I think, to the rest of the country.

Many times my colleagues will say to me, "Why you always talking about AIDS?"

And I said, "But what would you do if 15,000 people in your district died of something? Would you not be in a rage about this? You wouldn't do anything else but to make sure that it stops in your own area, but that other people would not have to suffer through this.

So in terms of the $2.5 billion that Dr. Coates was talking about, all the money that we spend on AIDS, which I believe is well spent, is an investment not only in terms of helping to prevent people from getting AIDS or improving the quality of their lives with the new therapies. And again Steve Warren, I know we'll remember the evening that we are fighting for that $100 million and Senator Specter came through for the ADAP funding, again not only supplying more money but raising the base level of the Ryan White and the CARE money.

Senator SPECTER. At 2 a.m. one day.

Ms. PELOSI. It was something we could not take no for an answer on it as you know. But, anyway,——

Senator SPECTER. Who gets the last word?

Ms. PELOSI. In any event the $2.5 billion, as much money as that sounds and, yes, you can call me on it when the Democrats are in power. Hopefully, we will have a Democratic President, as well.

It may sound like a lot of money, but it's a small amount to pay for the lives that it will save. And we have to, as Ms. Mann said, educate the public as to why this investment is important and why, even if you're just doing it from standpoint of budget, even if you're not even thinking in humanitarian terms, that it is a good investment and it will save money in the end.

So although the President didn't have all in the State of the Union that we thought he might, on the first glimpse that we saw of it, he did have it in his budget and that's where it really counts. And I'm so glad for the first time at least there's a reasonable increase for prevention. I'm totally dissatisfied, mind you. I mean, it's certainly not enough. But at least the recognition that we had to go in a different direction.

So while we do what we have to do at the public policy level, you would all know that all of that is for naught the excellent solutions and answers that come from the community, whether it's dealing as you do, Ms. Flournoy, with people every day in the way that you do so excellently or in the scientific community, all of it here has been on the basis of collaboration, of sharing information, of community-based solutions, whether it's prevention, care or treatment.

And in the little time that I have left I'd like to yield to Mr. Payne and Ms. Flournoy again for any insights they might add to how they think we could be more receptive to what you're talking about at the community level.

Mr. PAYNE. Well, mine is brief. I think the key is that we just need to be sure that the funding there for the prevention programs that are being developed to be target specific. I mean, you have to look at the different communities that are being impacted and gear your prevention programs thinking about the needs of the people you are dealing with.

And my concern or my fear is that, as we look at the funding, that we don't take money away from efforts that are prevention, because we also need the medical attention and the scientific attention. And this is layperson's viewpoint now. I mean they are people around the table who I have a lot of respect for, and I know they know a much more eloquent way of saying this.

But for me it's very important that every piece of that puzzle you talked about, whether it's prevention or whether it's a care, or whether it's the new treatments, has adequate funding.

Ms. FLOURNOY. And I think that providing the technical assistance that agencies need to do the work in an intensive kind of way. Rather than just applying basic research strategies and expecting those strategies to solidify themselves into change in the community, I believe that we need the technical assistance from those researchers who have developed these strategies and their way of interpreting or reinterpreting their findings into a community that lacks resources, into a community that has not responded to research practices in the past.

I think this a unique issue in our community and outcome measures, outcome evaluations will not effectively show what is happening in the community. And so linking agencies to research I think is a really important thing. I know that that has happened with the CAPS, and we are very pleased with that kind of work.

But I think that when you're trying to translate research into practice in our communities that those other variables are going to influence the outcomes. And we are being challenged to produce outcome data or evaluation data which talks about our effectiveness of being able to attack this disease. And so I think that that's going to be the challenge for us.

And again if you continue to support that, if you continue to support the intensive relationship, the intensive work between agencies and researchers, I think that that will help to empower us as agencies to do the work.

Ms. PELOSI. Thank you very much.

Senator SPECTER. Oh, fine.

Dr. COATES. Senator Specter, may I just make one brief final statement?

Senator SPECTER. Go ahead, Dr. Coates.

Dr. COATES. And I would ask that another document be entered into the record. This is a document called "Discovering Global Success." We invited 400 delegates from around the world to derive a basic evidence-based prevention package, so that Chairwoman Pelosi attempts to raise that battleship, here is the blueprint, and it will be in the record.

Ms. PELOSI. Thank you.

Senator SPECTER. It will be part of the record, as will all of your statements.

DISCOVERING GLOBAL SUCCESS: FUTURE DIRECTIONS FOR HIV PREVENTION IN THE DEVELOPING WORLD

[By Stephen F. Morin, Ph.D., Margaret A. Chesney, Ph.D., and Thomas J. Coates, Ph.D.]

In collaboration with the Participants in The Fogarty Workshop on International HIV/AIDS Prevention Research Opportunities—AIDS Policy Research Center & Center for AIDS Prevention Studies.

THE BASIC PREVENTION PACKAGE

The model-country planning process resulted in what constitutes a basic HIV prevention package. Various elements of the package are given higher priority depending on the specific characteristics of each country. These components are not presented in order of priority; the inclusion of any element and its relevant priority would be established through a country-level planning process. The basic HIV prevention package includes the following:

—HIV counseling & testing
—STD Treatment and counseling
—Screening the blood supply
—Basic information & education campaigns
—Youth & school-based education
—Condom availability & social marketing
—Sentinel surveillance
—Targeting those at increased risk
—Clean needle availability
—Treatment to prevent vertical transmission
—Positive policy environments

HIV counseling & testing

Knowledge regarding HIV status is an important component of preventing further transmission. The availability and promotion of HIV counseling and testing is an

important component of international HIV prevention activities. Such counseling should be as "risk free" as possible and can be targeted to individuals or to couples or offered in the context of whatever health care infrastructure exists in a given country.

STD Treatment and counseling

Because sexually transmitted diseases (STDs) increase the biological vulnerability to infection with HIV and the potential to transmit to others, the availability of programs to diagnose and treat such diseases is an important component of international HIV prevention programs. Counseling in the context of STD treatment should focus on methods of HIV risk reduction and may be linked to programs for condom availability and instruction in proper condom usage.

Screening the blood supply

While the screening of a country blood supply for HIV may be taken for granted in industrialized countries, funds for such blood safety efforts frequently run out during parts of the year in many of the least developed countries. Therefore, adequate funding and planning for the necessary kits to screen the blood supply should be part of action plans for counties where the governments can not assure the ongoing screening to protect the available blood supply. Comprehensive blood donor and blood component screening should also screen for other possible bloodborne pathogens. Policies should promote voluntary blood donation, self-deferral for individuals who perceive themselves to be at risk, avoidance of indiscriminate blood transfusion, and encourage auto-transfusion whenever possible.

Basic information & education campaigns

Awareness of HIV and possible modes of transmission are necessary components of HIV prevention. Particularly with nascent epidemic patterns, public awareness of the potential threat of HIV as well as public information on how to avoid infection should be a component of a comprehensive HIV prevention plan. Education programs and specific communication plans need to reflect the best strategies for reaching the general public as well as individuals and groups that may be at increased risk.

Youth & school-based education

School-based HIV education focusing on life skills and modes of preventing HIV infection can be an important part of a comprehensive country-level HIV prevention plan. Because HIV infections are occurring at very early ages in many developing countries, these school-based and youth outreach programs need to begin before young people are likely to be placed at risk of sexual transmission. Education level is often a predictor of risk for HIV infection in developing countries, particularly among girls and young women. Policies that promote education for girls and young women may themselves be a part of a comprehensive country-level HIV prevention plan.

Condom availability & social marketing

Condom availability is an essential part of preventing sexual transmission of HIV. Social marketing techniques can both increase the sale of condoms and promote the understanding of the need to use condoms properly. Free condom distribution may be a priority in many countries, particularly coupled with peer education targeted to commercial sex workers and other groups at increased risk. Careful efforts may be needed to work through religious group resistance to condom promotion and distribution.

Sentinel surveillance

Knowing about the prevalence and incidence of HIV infection can be of assistance in monitoring the epidemic and planning an adequate response. Surveys of the prevalence of infection in groups that are believed to engage in high-risk behavior—commercial sex workers, injection drug users, men who have sex with men, STD patients, and men in the military—can help identify the pattern of the epidemic. These studies are generally unlinked to a name or other identifying information. Such studies among groups thought to be at generally low risk, e.g. pregnant women at antenatal clinics, can help determine the extent to which the epidemic has moved to the general population. Because of limited resources, sampling techniques for surveys at sentinel sites would generally be the most practical approach in developing countries.

Targeting those at increased risk

In the case of a concentrated epidemic pattern, it is important to target limited resources to interventions aimed at those individuals and groups at greatest risk for

acquiring HIV or transmitting HIV to others. In some developing countries this may involve efforts to work with commercial sex workers and their clients to promote condom availability and proper use. Similarly the target group may be members of the military, truckers or others with increased numbers of sexual partners. In other countries the epidemic may require working with injection drug users and their sexual partners to promote the availability of clean injection equipment and condom use with sexual partners. Men who have sex with men may also be a group at particular risk in some countries, in which case those countries must find ways to target interventions to reduce sexual risk taking. Condom availability and promotion of proper condom use as well as other techniques to promote safer sexual practices are essential interventions.

Clean needle availability

Injection drug use and the reuse of needles in medical settings can be primary vectors of HIV transmission in certain parts of the world and are becoming problems in more countries each year. The availability and promotion of the use of sterile injection equipment is an important intervention to prevent such transmission. An early and aggressive response to HIV transmission through injection drug use is essential to prevent extensive further HIV transmission to sexual partners. Clean needle availability, e.g. needle exchange programs, are best when operated in the context of a comprehensive plan for preventing the sexual transmission of HIV and also when referral to drug treatment is provided.

Treatment to prevent vertical transmission

HIV transmission from infected mothers to their newborn babies is of particular concern in developing countries. Such transmission may occur before, during or after birth through breast-feeding. Medical treatments to prevent the transmission from mother to child are available in most industrialized countries, but even shorter courses of treatment may not be affordable in some of the least developed countries. The availability of voluntary counseling and testing for pregnant women is a first step along with education on HIV prevention in family planning clinics. In some cases, alternatives to breast-feeding may be practical, in other situations such alternatives may not be available.

Positive policy environments

Different public policies within countries may either inhibit or promote HIV prevention interventions. The status of women and human rights protections for people infected with HIV are important to the policy environment within developing countries. So are policy decisions about the allocation of resources to address the epidemic. Other more specific policies, e.g. tariffs on condoms, criminalization of sterile needle possession, restrictions on content of school-based education on sexuality, etc., may also inhibit HIV prevention. Country-level HIV prevention plans may include recommendations to foster a more positive policy environment.

PRIORITIES FOR INTERNATIONAL HIV PREVENTION RESEARCH

Each of the model-country planning groups developed recommendations for priority HIV prevention research. The recommendations followed from identification of areas of research that were lacking as they attempted to set priorities for HIV prevention interventions in the context of the model-country. When taken together, these recommendation provide a description of needs clustered into five general categories:

Global Priorities

A set of urgent prevention research needs with global implications emerged repeatedly. These are major issues that go beyond our current research activities.

—How can we accelerate policy changes that promote prevention?
—How can young women in high incidence areas be protected from sexually transmitted HIV?
—What can be done to respond to gender inequity and lack of educational opportunities for women?
—How can youth be better protected from HIV infection?
—How can short course anti-retroviral therapy to prevent perinatal transmission be adapted to meet the realities of developing countries?
—How can the use of alcohol as a risk factor be incorporated into HIV prevention planning?
—How do we better understand and remove stigma and find solutions to HIV-related discrimination?

Effectiveness Research

The effectiveness of prevention interventions needs to be assessed in terms of specific outcomes in developing countries. These studies would focus on the behavioral or health outcomes of HIV prevention interventions. Effectiveness can be assessed by such outcomes as increased knowledge, changed attitudes or social norms, decreased risk-taking behavior, and incidence of STDs or HIV-infection. The goal of these studies is to develop empirical data based on scientifically controlled studies to inform judgements about effectiveness.

—Does a specific STD treatment program reduce the risk of HIV infection in a given area of the country?
—Does any given public information campaign change the level of HIV knowledge in the general population?
—Does a specific condom availability and condom social marketing campaign reduce the incidence of STDs and HIV?

Cost-Effectiveness Research

Because developing countries have major limitations with resources, cost-effectiveness data are seen as essential to improved decision-making. Such research allows planners to assess the relative advantages of one intervention over another in the context of limited resources. The goal of cost-effectiveness studies is to determine the cost of each infection averted as the result of specific interventions. If data are gathered using standard measures, then comparisons can be made to help inform priority setting for interventions.

Operations Research

The basic prevention package of interventions sets out a number of options for specific interventions that could be adapted to situations in any given developing country. However, what is often needed is research on ways in which any intervention can be adjusted to the specifics of a given country. This concern addresses the important considerations of culture and attempts to build on what has previously worked in any given country. The specific goals of these research projects would be to take the conceptual framework of the interventions in the basic prevention package and test how these may be implemented in specific countries.

—Should STD treatment be made available in alternative health settings?
—Should counseling and testing be offered to couples as well as individuals?
—Should education and risk reduction communications come from government or non-governmental sources?
—Should youth education be school-based or community based?

Sentinel Surveillance

The task of planning to implement specific HIV prevention interventions targeting specific groups or regions at increased risk is often difficult because of the lack of adequate surveillance data. Developing countries could benefit greatly from simplified basic technology for gathering sentinel surveillance data and making projections about both prevalence and incidence of HIV infection within geographic regions of the country.

HIV PREVENTION PLANNING PROCESS

International participants in the workshop were clear that HIV prevention planning needed to be country-driven rather than donor driven. This requires valuing local expertise when designing interventions and setting priorities. Participatory planning requires a range of perspectives, helps develop consensus and leads to resource mobilization. Because certain functions like screening the blood supply are generally government functions, representation from the government is important. However, non-governmental organizations are central to the success of HIV prevention in most countries and such representation is essential. In addition, the success of planning efforts requires that all affected communities within any country be represented in a meaningful way. Ideally, the planning process would involve representation of all the major stakeholders in the country.

The model-country planning process illustrated the extent to which priorities would be quite different depending on the stage of the epidemic—nascent, concentrated or generalized—and the extent to which the availability of resources shapes decision-making. Conducting a needs assessment begins with a review of what is known about the epidemiology of the epidemic and results in a series of questions that need further clarification. Once some consensus is reached about the problem, the planning involves setting priorities for meeting the identified needs. Groups essentially choose from the basic prevention package the interventions that in their view are most likely to accomplish their goals. Ultimately, decision making

is both data-based and value-based. The more investment in a quality planning process the more likely the success of the country-level HIV prevention program.

Country Level Planning Process

Ensuring non-governmental participation
Ensuring governmental representation
Valuing the planning process

Country-Level Planning Tasks

Developing an epidemiological profile
Assessing and setting priorities for targeting groups, if indicated
Selecting among a basic package of HIV prevention interventions
Evaluating programs

Additional Resources

Constructing a budget within existing resources
Mobilizing resources to respond to unmet needs

MOBILIZING RESOURCES

Responding to the challenges of the HIV epidemic in the developing world will clearly require mobilizing more adequate resources.

UNAIDS figures establish the need for action—over 30 million adults and children living with HIV by the end of 1997. Another 12 million people have already died of AIDS around the world. And, 89 percent of these cases are in the developing world, which has only 10 percent of the world resources. In addition, the situation appears to be getting worse—not better—with an estimated 5.8 million new infections during 1997. This obviously requires a coordinated global response.

Based on earlier cost estimates developed by the Global AIDS Program at the World Health Organization, we estimate that implementing this basic prevention package would cost approximately $2.6 billion. This funding would need to come from within countries and from an increased effort on the part of donor nations.

The U.S. investment in international prevention efforts through the U.S. Agency for International Development (USAID) was $121 million in 1998. These funds are largely used for bilateral programs in Africa, Asia and Latin America. About 14 percent of the funds are used for multilateral programs through UNAIDS; the remainder are used to support core functions, including operations research on how to improve the effectiveness of the prevention efforts.

The National Institutes of Health (NIH) classified $58 million of its AIDS spending in 1998 as international research, and this is expected to grow in future years. The NIH has established HIVNET, the HIV Prevention Trials Network, to rapidly test both behavioral and biomedical approaches to HIV prevention. Sites are located throughout the United States and in 8 developing countries. NIH is also actively involved in training international AIDS researchers through the leadership of the Fogarty International Center. Through 1998, over 1,300 researchers from over 90 countries have received training in the United States.

Greater leadership is needed from both the United Nations and the G–8, the group of eight major industrialized countries—the United States, the UK, France, Japan, Germany, Canada, Italy, and Russia. Together these countries control over half of the International Monetary Fund (IMF) and the World Bank. When united, the G–8 can exert considerable influence.

The success of any effort to raise the necessary funds to support the implementation of this basic HIV prevention package will depend on international mobilization. A first step is to raise the visibility of the international AIDS issue. Then, organizing at the grass-roots level is very important. Leaders within countries and leaders of donor nations need to hear from concerned individuals and from the scientific community about the importance of immediate and sustained action.

Senator SPECTER. And we——

Ms. PELOSI. I'm not finished. Will the gentleman yield? Will the chairman yield?

Senator SPECTER. Well, I was about to call on you as soon as I thanked people. But I will——

Ms. PELOSI. You can have the last word.

Senator SPECTER. I doubt it.

Ms. PELOSI. I want to thank Lonnie Payne and Doretha Flournoy for their excellent presentations.

Dr. Coates, as you know, it's really one of the champions, the hero, for so many years sustaining the effort, and for sharing your own personal experience with us and giving us the blueprint for how we can go forward.

Doretha, if anybody needed to know anything about your commitment, which I think they do not, and your dedication on this issue that you would be with us on this day is a real tribute to you as a person and your concern for people. So we are forever grateful. No words are adequate to thank you enough.

Senator Specter, thank you. We have many resources in this room on this issue, who have worked on this issue for a long time, and many in our community.

On behalf of Mayor Brown, in addition to my own gratitude on behalf of my constituents, I want to thank you for having this hearing in San Francisco. Thank you for your leadership on this issue. Again thanks for the $100 million. It was a good start.

And thanks also for your work on the minority AIDS issue, and being there for us all the time, because in doing so the Senator is usually alone in his party on this. And you don't have to comment on that, Senator.

But in any case, thank you for your leadership and for your attention to our concerns here. Welcome to San Francisco.

Senator SPECTER. Aside from the comments about me, I had intended to say just that. So we will give to Congresswoman Pelosi the last word.

CONCLUSION OF HEARING

Thank you all very much for being here, that concludes our hearing. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 2:01 p.m., Monday, February 14, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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